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Senate

The Senate met at 9:45 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

O God, our Father, the way, the truth, and the life, lead us to Your truth. Keep us from twisting the truth to conceal our mistakes. Keep us from evading the truth we do not wish to see. Keep us from silencing the truth because we are afraid of people.

Infuse Your Senators today with a passion for truth that will save them from false words or cowardly silence.

Teach us all to speak Your truth in love.

We pray in Your holy Name. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, leadership time is reserved.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, in just a few minutes, at 10 a.m., the Senate will proceed to the vote on invoking cloture on the motion to proceed to the small business health plan bill. Chairman ENZI is here, and there will be a few minutes for closing remarks before that vote. If cloture is invoked, I hope we will be able to proceed to the bill today and begin debate on the substance of the legislation.

Today, the two party policy luncheons will occur between the hours of 12:30 and 2:15 p.m. Once we determine when we will be able to proceed to the small business health plan bill, we will then set up a recess to accommodate those two meetings.

HEALTH INSURANCE MARKETPLACE MODERNIZATION AND AFFORDABILITY ACT OF 2006—MOTION TO PROCEED

The PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration on the motion to proceed on S. 1955.

The legislative clerk read as follows:

Motion to proceed to Calendar No. 417, a bill (S. 1955) to amend title I of the Employee Retirement Income Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace, and for other purposes.

The PRESIDENT pro tempore. Under the previous order, the time until 10 a.m. shall be equally divided between the Senator from Wyoming, Mr. ENZI, and the Senator from Massachusetts, Mr. KENNEDY, or his designee.

The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I am here this morning to ask this body to support the motion to proceed to the debate. All we are voting on is whether we are going to get to debate, not whether we are going to have health insurance for small businesses. But if this vote does not get 60 votes, we will not have the opportunity in this Congress to see whether we can help out small businesses across this country.

The bill before us will provide for small businesses to be able to join across State lines to negotiate against the insurance companies with enough power to make a difference. This is something which the small businesses have been asking for for almost 15 years. In the last 12 years, it has passed the House eight times but has never even gotten out of committee in the Senate until this year. The reason it got out of committee is because we have drastically changed the bill. We are not talking about the old association health plans we had in the past. This is one which has had some modifications that have been helped with insurance companies and State insurance commissioners. It still keeps the power of oversight and consumer protection in the hands of the State insurance commissioners, but it does allow the ability to unify things so that we can get across State lines.

How is it doing? Well, the Washington Post says it went too far. The Wall Street Journal says it didn't go far enough. So maybe we are somewhere right there in the middle. But unless we get to debate this issue, we will never know until we can get through the motion to proceed and possibly 30 hours of still debating whether we are going to debate before we ever get to a motion. So I am hoping that this morning we can pass this motion to proceed.

I can't believe that any Senator here hasn't heard from enough small businessmen that he wouldn't allow us to proceed to the debate. I am hoping that following that motion to proceed to debate, we can limit the hours of debating that particular motion and get on with the substance of trying to perfect a bill.

In my 9 years in the Senate, I have never seen a perfect bill. I am not saying this is a perfect bill. I am saying it is one that has come out of compromise, long discussions, and has moved away from the point of huge objection on the Senate side to less objection on the Senate side. It is a bill that can be worked out, can be passed, and can have a significant difference for

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

small companies across the United States.

Will it make a difference? There are several surveys that say it will make a difference. I am saying that from the amount of advertising which was done before we even had the motion to proceed, there must be a lot of big bucks in savings in this thing to have the kind of opposition we have already had on it. But we will never know unless we get the right to debate. So I am asking my colleagues to vote aye on the motion to proceed so that we can proceed to a debate, sometime within the next 30 hours, hopefully.

Mr. President, I reserve the remainder of my time.

The PRESIDENT pro tempore. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, I ask the Chair to let me know when I have 1 minute remaining.

Mr. President, this should be a historic week. The Senate has the opportunity at last to have a debate on the basic questions of health care. Senator ENZI has put forward a proposal that deserves debate and the opportunity for amendment, and I commend him for his diligence in bringing forward his proposal. But after careful study and debate, I believe the Senate will conclude that the course laid out in this proposal is the wrong one for health care.

The legislation will make health care coverage less affordable and less accessible for millions of Americans. It will raise premiums for Americans when they are older or when they fall ill. It will mean the end of laws to guarantee coverage for cancer, for diabetes, for mental health parity, and other essential services. It will undermine the laws that protect consumers from fraud and abuse, and it will give no real help to the self-employed.

We have a better approach. The proposal offered by Senators DURBIN and LINCOLN will allow small businesses to band together to get the same low rates offered to larger employers. It provides real help for small businesses with the high costs of health care through tax credits and reinsurance programs to defray the cost of the most expensive claims.

When our debate concludes, I believe the Senate will agree with the over 200 organizations that have written letters of opposition to this legislation. These organizations represent patients with diabetes and cancer and mental health needs. They represent older Americans, workers, health care professionals, small businesses, and Americans in all walks of life. They represent the over 15,000 Americans who have called the Senate to ask this body to oppose legislation that will take a step backward from our commitment to quality health care, and they represent the millions more who will be harmed if we do not reject the legislation before us.

We have heard from Governors, insurance commissioners, and attorneys general from Maine to Hawaii and from Florida to Alaska, and all of them—all of them—have urged the Senate to reject this bill.

I urge my colleagues to oppose the current legislation, but I hope they will vote to proceed to consideration of this bill. The Senate has been denied the chance to take action on major health priorities for too long. Next week, seniors will be forced to pay a steep penalty if they are unable to navigate through the tangle of confusing Medicare plans and options. The Senate ought to vote on Senator NELSON's proposal to let seniors make their choice without the threat of heavy fines if they do not meet this arbitrary deadline.

The Republican Medicare law also includes a provision so contrary to commonsense that people hardly believe you when you tell them it was included. The legislation makes it illegal for Medicare to bargain for discounts on drugs for seniors. We have a proposal to end that shameful prohibition, and we should vote on that proposal.

On Medicaid, we should take action to end the cruel cuts imposed on the poorest of our fellow citizens by the Deficit Reduction Act, which paid for tax cuts for the wealthy through health cuts for the poor.

We have been promised and promised that the Senate would vote on drug importation, but the vote never comes. Senator DORGAN, Senator SNOWE, Senator MCCAIN, and I have a proposal that will allow safe importation of lower cost medicines from Canada and elsewhere. Surely, Health Week is the time for a vote.

Before the week is out, the Senate should see that the promise of stem cell research—stem cell research—is no longer denied to the millions of patients and their families who look on with anger and bewilderment as the bill passed by the House languishes for month after month after month in the Senate. And we have failed year in and year out to fulfill the promise of this century of the life sciences by making quality care a right for every American. Let us at long last take action to extend quality care to every American.

So I say to my colleagues: Vote for cloture on this motion. Vote for a health care debate. Vote for a chance to go on record with your answer to these important questions on Medicare, on Medicaid, on stem cell research, on drug importation, on coverage, and on many other health priorities. Let's have a debate, and let's let the Senate decide where it stands.

Mr. President, I reserve the remainder of my time.

The PRESIDENT pro tempore. Who yields time?

Mr. ENZI. Mr. President, I thank the Senator from Massachusetts for his encouragement on his side of the aisle to vote for the motion to proceed. I think that will get us into a debate that will make a difference for the working people of America, the people up the street and across the street, the working families that are a part of small business.

Today, there are 45 million people in the United States who are without health insurance in this country. Twenty-two million people own or work for small businesses or live in families that depend on small business wages, and another 5 million are unemployed. Those are the 27 million people we are talking about whom this health care bill will be making decisions for in the next few days.

It is long past time for Congress to take some action. The American people aren't going to accept excuses any longer. It has been a long time getting to this debate. I am pleased that it sounds like we will be able to have it. I welcome any amendments that are alternate approaches or improvements to this bill. I know what the complaints are out there, I know what the counters to those are, and I know what the concerns are. It is very important that when we walk away from this week, we walk away with a plan which will help the small business people of the United States, the ones working for small businesses, the ones owning them, and their families who need the help.

Mr. President, I reserve the remainder of my time.

The PRESIDENT pro tempore. Who yields time? Each side has 1 minute remaining.

Mr. KENNEDY. Mr. President, I will mention at this time some of the organizations. We will have a chance during the course of the debate to get into the reasons why. The American Academy of Pediatrics; the American Cancer Society; the Diabetes Association; the Nurses Association; Families USA; the lists of Governors—and I will include those—more than probably 15, 18 Governors; the attorneys general. I think there are probably close to 40 of the attorneys general representing States North, South, East, and West who have opposed this bill. The Insurance Commissioners of the States—a whole list of those. At the appropriate time, I will include those in the RECORD.

I hope our colleagues will put their ear to the ground and find out what people are saying back home, what your cancer society, diabetes, pediatric nurses and doctors are saying about this, what the attorneys general are saying about this, and what those in the medical profession are saying about this. We think we have a better way to help small business, and during the course of the debate, we will show how that can be done.

Mr. President, I yield the floor.

The PRESIDENT pro tempore. The Senator from Wyoming has 56 seconds.

Mr. ENZI. Mr. President, I thank the Senator from Massachusetts for listing those 200 organizations. I have never done a count on them, and I am not familiar with quite that many; I am only familiar with about 40 that have expressed some concern that I suspect will be taken care of in amendment if we can get to the amendment process.

I would like to mention that there are over 200 business organizations that are looking forward to being able to unite these people across State lines to get lower rates for their people. There are actually 80 million employees in those businesses, in those organizations. The realtors are going to be here with 9,000 people next week, expecting that we will have already taken action. The National Federation of Independent Businesses is another big one that is supporting this. I could mention a lot more. Even some of the associations that have concerns about it want to be sure that this bill passes so their employees can be covered.

I yield the floor.

CLOTURE MOTION

The PRESIDENT pro tempore. By unanimous consent, pursuant to rule XXII, the chair lays before the Senate the pending cloture motion, which the clerk will report.

The legislative clerk read as follows:

CLOTURE MOTION

We the undersigned Senators, in accordance with the provisions of rule XXII of the standing rules of the Senate, do hereby move to bring to a close debate on the motion to proceed to Calendar No. 417, S. 1955, Health Insurance Marketplace Modernization and Affordability Act of 2005.

Bill Frist, Johnny Isakson, Sam Brownback, John Thune, Thad Cochran, Wayne Allard, John Ensign, Richard Shelby, Larry Craig, Ted Stevens, John McCain, Lamar Alexander, Norm Coleman, Judd Gregg, Pat Roberts, Craig Thomas, Richard Burr.

The PRESIDENT pro tempore. By unanimous consent, the mandatory quorum call has been waived.

The question is, Is it the sense of the Senate that debate on S. 1955, the Health Insurance Marketplace Modernization and Affordability Act of 2005, shall be brought to a close? The yeas and nays are mandatory under the rule.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. ROCKEFELLER) is necessarily absent.

I also announce that the Senator from North Dakota (Mr. CONRAD) is absent due to illness in family.

The PRESIDING OFFICER (Mr. DEMINT). Are there any other Senators in the Chamber desiring to vote?

The yeas and nays resulted—yeas 96, nays 2, as follows:

[Rollcall Vote No. 117 Leg.]

YEAS—96

Akaka	Cantwell	Dorgan
Alexander	Carper	Durbin
Allard	Chafee	Ensign
Allen	Chambliss	Enzi
Baucus	Clinton	Feingold
Bayh	Cochran	Feinstein
Bennett	Coleman	Frist
Biden	Collins	Graham
Bingaman	Cornyn	Grassley
Bond	Craig	Gregg
Boxer	Crapo	Hagel
Brownback	Dayton	Harkin
Bunning	DeWine	Hatch
Burns	Dodd	Hutchison
Burr	Dole	Inhofe
Byrd	Domenici	Inouye
Isakson	McCain	Schumer
Jeffords	McConnell	Sessions
Johnson	Menendez	Shelby
Kennedy	Mikulski	Smith
Kerry	Murkowski	Snowe
Kohl	Murray	Specter
Kyl	Nelson (FL)	Stabenow
Landrieu	Nelson (NE)	Stevens
Lautenberg	Obama	Sununu
Leahy	Pryor	Talent
Levin	Reed	Thomas
Lieberman	Reid	Thune
Lincoln	Roberts	Vitter
Lott	Salazar	Voinovich
Lugar	Santorum	Warner
Martinez	Sarbanes	Wyden

NAYS—2

Coburn	DeMint

NOT VOTING—2

Conrad	Rockefeller

The PRESIDING OFFICER. On this vote, the yeas are 96, the nays are 2. Three-fifths of the Senators duly chosen and sworn having voted in the affirmative, the motion is agreed to.

Mr. ENZI. Mr. President, I ask unanimous consent that the postcloture debate on the motion to proceed be divided as follows: From now until 11 a.m. will be under majority control; from 11 to 11:30 will be under minority control; 11:30 to 12 will be under majority control; and noon to 12:30 will be under minority control.

The Senate will stand in recess from 12:30 to 2:15 p.m. I ask that time count under the provisions of rule XXII. The time from 2:15 to 2:30 will be equally divided between the majority and minority; from 2:30 to 3 we begin majority control, with the next 30 minutes under minority control, and each 30 minutes rotating in this format until the hour of 5:30 p.m.

Before the Chair rules, we would like to make out a time certain to begin consideration of the bill. In the interim, this unanimous consent allows the Senate to have an orderly debate for speakers.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENZI. Mr. President, I thank virtually all Members in the Senate for their help in getting the motion to proceed. That will allow us to do 30 more hours of debate before we actually get into the substance of making any changes in the bill. I hope we can work out a unanimous consent agreement that will shorten that time and get us into the meat of the debate. I will push for some rapid consideration of some amendments so we can get this resolved for the small businessmen of this country in short order.

I will address some of the charges made against this bill. I listened yesterday and the day before to the minority leader's speech to the Senate on Friday. I was surprised by several of the statements he made regarding this bill. If I had not already known that he was talking about S. 1955, I would never have guessed it.

The first comment the minority leader made was that our bill threatens the coverage of those who have insurance now and does nothing to extend coverage to those who need it. I make two points in response to that. First, it seems to me the status quo is what is truly threatening the coverage of those who are insured now. Prices are going up dramatically. Small business has no leverage. No one can afford more of the same or more excuses from Washington.

Blocking an honest debate on this bill is a vote for more of the same. It is a vote for health insurance costs continuing to rise dramatically, for more small businesses dropping coverage for their employees, and for more uninsured American families. Year after year of more of the same is what is truly threatening America's health care security.

Second, this bill will indeed extend coverage to more people who need health insurance. If you do not believe me, listen to our nonpartisan CBO. The CBO says this bill will reduce health insurance costs for three out of every four small businesses. The CBO also said the bill will extend private health coverage insurance to 750,000 more people than have it today.

Is that a comprehensive solution to the problems of health care and the uninsured? Of course not. I understand this is not a comprehensive solution to the problem of health care costs and the uninsured, but it is definitely a step in the right direction and a building block for the future.

I have more comments about statements made about the bill in ads and in editorials, but at this point, I release the remainder of our time until 11 o'clock to the Senator from Missouri who has been working on this in the House for years in a totally different version but has brought his expertise, talent, and knowledge to this side of the building. He has been a strong advocate for doing something for small businesses. He has been extremely cooperative in finding ways to do things so we can have something for small businesses.

I relinquish the floor to the Senator from Missouri, Mr. TALENT.

Mr. TALENT. Mr. President, I thank the Senator from Wyoming for his kind words and his great work and his comments regarding my involvement with the idea of small business health plans. What he said is true regarding my involvement. I am not the father of this idea, but I think I probably ''midwifed'' it years and years ago when I served in the House in 1997. It has passed the House on a regular basis ever since then and, as the chairman knows, on a very strong bipartisan basis because the idea of small business health plans is fully within the mainstream of both parties' thinking which is one of the very powerful arguments in favor of it.

The No. 1 issue facing small business today as a whole is not energy costs, although certainly they are too high. It is not immigration, although that is definitely an issue. It is not taxes, although we all hear our share of complaints from small business people about that. It is the rising cost of health insurance and the number of

people who do not have health insurance. That is largely a small business problem.

There are 45.8 million Americans who are uninsured today, 4 million more than 2001. That number has grown every year, in years of prosperity or recession. The vast majority of those uninsured people are working people. And most of those working people are people who work for a small business. They work for a small business, they own a small business, or they are dependents of someone who works for or who owns a small business.

The smaller the business is, the worse the problem gets. Only 40 percent of businesses with 3 to 6 employees today have health insurance for their employees and that number is down from 52 percent in 2004 and 58 percent in 2002.

We are entitled to ask ourselves, Why? I have heard a lot of explanations over the years. Why does small business have a problem providing health insurance for its employees whereas bigger companies don't? You would be surprised at the explanations offered. I had one witness from the Government Accountability Office tell me that he did not think employees of small business wanted health insurance. I have other people speculate that small employers did not care as much about their people who work for them as big companies do. That certainly will come as a revelation to Senators that big corporate employers care more about their employees than the small business owners and managers do—the small business people who work on a daily basis with their employees, the small business people who would like to get health insurance themselves from the small business if they could figure out a way for the small business to provide that health care to the employees.

It is not a question of the small business people caring enough. The problem is, the cost and complexity of getting health insurance for a small business is greater than it is for a big business. It will surprise no one who has common sense that it is harder to insure a small market, a small group, than a big group. The cost of insurance is less if you can spread it across a bigger pool of people. This has been studied extensively, and that very commonsense conclusion has been validated.

I will go over some of the figures for the Senate. Health insurance premiums for small business people increased by 10.9 percent in 2001, 12.9 in 2002, 13.9 in 2003, 11.2 percent in 2004, and 9.2 percent in 2005.

The smallest firms have always seen bigger increases in premiums. Why? Well, the SBA's Office of Advocacy has found that small businesses typically spend much more than large businesses for the same benefits. Not that the benefit packages are different, not that small businesses are trying to buy more expensive benefit packages; they have to spend more to get the same benefits because the administrative costs of some benefits are almost 14 times more for the smallest firms than for their largest counterparts.

According to the Government Accountability Office, from 20 to 25 percent of small employer premiums typically go toward expenses other than benefits compared with about 10 percent for large employers. The small business people are paying more to get the same benefits because they have higher overhead costs and higher administrative costs. They do not enjoy the same economies of scale the big companies enjoy.

The American people know this. I have a lot of stories from Missouri I could tell. I do not have the time. But the American people are living with this every day.

Jim Henderson is the president of Dynamic Sales in St. Louis. It is a third-generation family business that sells welding accessories and other products. It is a small business. He has eight employees. Health insurance has been a problem for 16 years for Jim. He spoke with his insurance agent, who suggested raising the deductible to keep the premium the same, so he has raised the deductible. It has gone from zero to a $1,000 deductible in the last 10 years. So despite that huge increase in the deductible, to this day, he experiences huge increases each time he tries to renew the policy. When he asked his carrier about the enormous increases and why they are raising his premiums so much, the carrier responded: Well, because we can.

Tammy Herbert is a certified optician from Farmington, MO. She is a cancer survivor. She had breast cancer. She is a single, working mom. She is an inspiration when you talk to her. She told me because of her history of breast cancer, 2 years ago her employer's insurer canceled all the individual policies for her and her colleagues.

People talk about small business health plans resulting in cherry-picking. They ought to see what is happening today in the small group market.

Renee Kerckhoff is the second generation owner of Rudroff Heating & Air Conditioning, in Belton, MO. She can only afford to cover a small portion of employee insurance premiums—about $150 a person per month. As a result, and despite her best efforts, her employees are having to drop their health insurance because they cannot afford the copays and the premiums they have to make and are going on public assistance.

These stories are happening all over Missouri and all over the country. Sometimes I will get with a group of people and ask them: Look, if you had a history of medical illness, and you had the choice of working for a big company or a small company, and all you cared about was health insurance, and all you knew about the companies was that one was a big Fortune 500 company and the other was a small company, which one would you work for? I have never had anybody raise their hand and say: I would work for the small company because the assumption is I am going to get better health insurance from the small business.

They know, because it is a matter of common sense, insuring a large pool of people is more efficient, more economical and, therefore, less expensive than insuring a small group of people.

Just look at the people who are insured in the country. Virtually everybody who has health insurance, except for the employees of small business people, have it as part of a big national pool. It may be public, it may be private, but it is a big national pool. They work for a big company. They are in a labor union. They are on Medicare or Medicaid or they are a Federal employee or a retired Federal employee or in the VA.

All these other organizations could insure on a small group basis if they wanted to. The Federal Government could go out and take each section of Federal employees in different cities and divide them all up and insure them in a small group. There is no law against that. Microsoft could do the same thing. Hallmark in Missouri could. Anheuser-Busch in Missouri could. They could insure each little section if they wanted to. Well, they do not because it does not make any sense. It would cost them more money to do it. Yet small business people have to do that every day.

So what is the answer? Well, there is a simple answer that is out there. Everybody tries to make it more complicated than it is, but it is simple: Empower the small business people to do what the big business people can already do. Allow them to pool together through their trade associations and get health insurance as part of a big, national, voluntary, efficient, economical pool.

I give an example: I think it is the best way to describe it. Take a restaurant owner such as my brother, who owns a little restaurant. It is kind of a tavern restaurant. It is a great place. It has great chicken sandwiches. And I highly recommend it to you if you get to Missouri. He does not have health insurance for his people. It is too expensive. It is complex and foreboding for him. He and my sister-in-law run the business. They do not want to have to wrestle with big insurance companies. They are afraid if something goes wrong, they could get sued. He would like to have health insurance. Then he could get it through the business, too.

Now, what if the National Restaurant Association could contract with big insurance companies? They could be his employee benefits section, just like big companies have an employee benefits section. By joining the National Restaurant Association, he automatically would have the right to join the big pool. They would send him the papers. They would show him the options he

has, and he could decide how much he wants to pay. He could let his employees pay the rest and join the pool. He could have health insurance as part of a big pool. It would be must-offer, must-carry. They would have to let him join the National Restaurant Association and would have to offer the health insurance to him.

When I chaired the Small Business Committee in the House, we studied this issue. And I have seen a lot of other studies since then. The best estimates I saw were that it would reduce premiums for small employers by 10 to 20 percent; a recent study came out and said 12 percent. There would be a million fewer people uninsured.

It costs the taxpayers nothing. It is not a Government program. It is empowering small business people to do what big business people already can do. I think the impact would be much greater than the studies have shown because right now the psychology of health insurance, if you are a small business, is so negative. I think you would see whole segments of the economy, which traditionally have not provided health insurance to their employees, begin to provide health insurance. And the restaurant business is one of them. It is one of the reasons the National Restaurant Association is so strongly in favor of this concept.

Now I have talked about this for almost 10 years. I lay it out for people, and they say to me: Well, who would oppose this? I actually get that question a lot: Who is opposed to it? And that is a good question. It is fully within the mainstream of both parties' philosophy. It is empowering the little guy, just like farm co-ops. It passes the House with a strong, bipartisan majority every year. And why shouldn't it?

What is the downside of it? The downside is: It does not work as well as we hope it is going to work. Not as many people go into it as we hope and believe will go into it.

It is not as though the taxpayers are going out on a limb. So who is opposed to it? Well, nobody will be surprised to hear that the big insurance companies have opposed it, and they have come up with all sorts of excuses over the years. I am not going to go heavily into it because the chairman has worked very hard to get as much consensus as he can get. But I will say this. I think they oppose it not because they are afraid it will not work but because they believe it will work. And they control most of the small group market now. I do not have time to go through those figures. But the concentration of the small group market within the five largest carriers has grown and grown and grown. And small business health plans would be a powerful, new competitive force in that market.

The State insurance commissioners have been concerned because these small business health plans would be national and they felt the State would not be able to regulate it. In fairness, I have to say, I have never agreed with that. Remember, the big companies already operate free of State regulation. That has been the law for 30 years. And we have not had any disasters as a result of that. I do not believe anything that has happened in the last 10 years or so is proof that we can trust the big companies more than we can trust the small companies.

If I had to decide who was going to be free of State regulation, I think I would rather have the small businesses free of that. And it is not as though the market the States have regulated never has any problems. There are a lot of insurance companies that go bankrupt, and the States have to take them over.

But the good news is that the chairman has squared this circle. He has worked out an arrangement for the regulation of small business health plans where many of the State regulations and much of the State regulatory authority will still apply. I am not saying the State insurance commissioners are standing up for his bill, but I think it is safe to say that many of their objections have been ameliorated, and the chairman has made much progress on that front.

Folks who tend to be sincerely on the ideological extreme on health care issues—and maybe ''extreme'' is the wrong word, but they want to go one way or the other—have been lukewarm about small business health plans. There are some who wish to eliminate the employer system and take the Federal tax deduction and pass it through to individuals and let them go out and buy health insurance on their own, and there are others who want a total Government solution. And this is not any one of those things.

It is a substantial and important and meaningful but incremental change in the world we are in. It makes things better for people on a day-to-day basis who are out struggling in the real world. Maybe it is not the reform that any of the think tanks on the right or left would come up with, but it makes a difference. It will help. There is little or no downside to it. We need to help the real people who are really hurting.

Finally—and this I understand entirely; I struggled with this myself in the years I had this bill—the groups that have worked to get various disease mandates in the States have been concerned. Because if you worked hard to get a mandate so that mammogram screening is covered in your State as a matter of right, and small business health plans go into a national pool, just like the big companies, if we do not do something, they would not be subject to those State mandates.

I have made a point in talking with these groups over the years saying that, look, the big company plans, the big pools that exist out there—the labor unions, the company plans, the Federal employee plans; all those sorts of things—they usually cover all those mandated coverages, anyway, because most of them are pretty common sense.

Again, remember, if you have been sick, and you have a choice of working for a big company that is not covered by the State mandates or a little company that is, which do you think has the better health insurance? The folks I have talked to over the years say: Well, we would go with the big company.

But I think we are going to be able to square that circle as well. Senator SNOWE is going to offer an amendment which will represent progress in this area. It will provide that if 26 States cover a mandate, that mandate applies to small business health plans, and it is protected in the States that have it. So this is progress. It is not just net progress; it is absolute progress for these various groups that have sought these protections because they are going to have, if that amendment passes—and, certainly, I am going to support it—they will have protections on the Federal level for the first time for these various coverages.

So I am very hopeful they will take a look at this. I believe with the amendment Senator SNOWE is going to offer, the concerns they had not only do not apply anymore, but actually they are going to be better off because for the first time we are going to have national pools set up under Federal law with certain basic patient protections and coverages that are guaranteed. As I said, I do not think those would be necessary because I think the pools would cover them, anyway. Most of those are pretty common sense. But we can put them in the law and reassure everybody. And I think we can make the bill better if we do that.

I see my time is running out, Mr. President.

So what is left? Why should we oppose this? I do not want to be presumptuous. I have lived with this bill for so long that maybe there are weaknesses I do not see. But this is something we can do for people. It passes the House regularly. They like it over there. It has a strong measure of bipartisanship, anyway. There is no real downside to it.

Let's debate the bill, and let's resolve that we are going to debate it with a view toward actually voting on it.

I hope nobody filibusters this bill. We can work out agreements about debate, work out agreements about amendments, and have a chance to help people. This is a problem. This is a case where people are hurting. I know politics is important here; I know this is an election year; I know all of that. But we can make a difference for real people on the ground every day who are worried about losing their health insurance or who do not have health insurance and are worried about getting sick. We ought to do it.

I thank the Senator for yielding. It looks as though my time has expired. I yield the floor.

The PRESIDING OFFICER (Mr. SUNUNU). The Senator from Connecticut.

Mr. DODD. Mr. President, I yield myself 20 minutes. Senator KENNEDY is

not here right now, but pursuant to previous agreement, I would like to be notified when 15 minutes expires so I can conclude my remarks in the 20 minutes.

I spoke yesterday about this legislation. I want to begin by saying to my friend from Wyoming, the chairman, I have a great deal of regard for him. I have enjoyed working with him on the HELP Committee. We do a lot of work together. I have enjoyed that relationship. It is with a note of sadness that I disagree with him about this bill. We had a lengthy markup. He was very patient to listen to all of our ideas and the amendments we offered during the markup. I appreciated his willingness to do so. But as happens from time to time, we have disagreements. They are not personal. They are ideas on which we have a different point of view. Today is one of those occasions. These remarks are in no way intended to denigrate the work of the chairman of the committee or those who agree with him.

There are those of us who believe strongly that this proposal would do a lot more harm than good, that, in fact, the cure being proposed with this legislation creates far more problems than presently exist, as bad as the present situation is. We know, as a matter of fact, that over the last 3 years, the premium cost for health care has risen: 9 percent in 2005, 11 percent in 2004, 14 percent in 2003. These costs continue to rise. A family of four today is paying about $11,000 in premiums for health care coverage. The problem is significant.

I regret in some ways—and this is not the fault of the chairman of the committee—that we are not debating in a broader sense how we might address the far more significant issue, as important as this one is, when we have 45 million fellow Americans with no health care coverage at all. I regret that we are not having a larger debate on that issue.

Secondly, I believe it is a legitimate issue to raise the issue of how small business is dealt with when it comes to insurance. In the next 2 days, we will offer a substitute to the proposal authored by the chairman of the committee, the Senator from Wyoming, that we believe will deal far more thoroughly with the legitimate issues that smaller businesses face. In fact, we redefine small business to mean businesses not with 50 employees or less but 100 employees or less, thereby covering more small businesses than would be covered by the legislation before us.

The problems are huge in the area of health care. If you do surveys of the American public and ask them to identify what are the largest concerns they have, if not the No. 1 issue—from time to time other issues may be more important to people—consistently year in and year out, people will tell you their great concern is about the fear of watching a family member or themselves be hit with a major health care crisis and not having the resources to pay for it, not being able to get the doctors, not being able to have the kind of care they would want for their families because they cannot afford the premiums that would provide them broader coverage, if they have any kind of coverage at all. They may not have any kind of health care. This is a major problem. We ought to be spending a lot more time addressing this issue than we are.

Having said that, let me talk about this proposal. I am deeply worried about it. It isn't just my concern. Many Governors, more than three-quarters of the attorneys general of the States which we represent, not to mention the health insurance commissioners of many States, have raised very serious concerns about this legislation. They are very worried about what this bill will do to their constituents, the States that we represent as Senators.

Let me share a letter from the Connecticut Business and Industry Association. This association represents 5,000 small employers in my State. This is not an organization that is known for its liberal tendencies. Quite the contrary, it is a very conservative business group. Listen to what my business group that represents the small businesses of my State has to say about this bill.

> We believe that in Connecticut federally certified AHPs would destabilize the small business insurance marketplace, erode carefully crafted consumer protections and raise premium rates for small businesses with older workforces and those that employ people with chronic illnesses or disabilities.

The letter goes on to say:

> Although the passage of AHP legislation would present us with opportunities to expand our CBIA health connection's product customer base as a regional offering, we do not believe that the proposed legislation represents a sound public policy for providing more affordable coverage or access to health care benefits. The proposed legislation does little to address the underlying causes of health care inflation, which is the most important barrier to small employers providing health care benefits.

That is a strong letter from an organization that represents 5,000 small employers in the State of Connecticut. They are worried about what this bill will do to smaller employers in my State in terms of their costs. They are deeply worried about this legislation and what it may mean.

Let me also share with my colleagues a second chart. This was a chart that was produced by Families USA, with estimates from the Agency for Health Care Research and Quality, a medical expenditure panel, and from the U.S. Census Bureau. It tells us the number of people that will be losing State regulatory protections if this bill is passed. What we are doing is shrinking the amount of benefits that can be offered. In my State, we offer a range of 30 different benefits—that was passed by my State legislature—that insurance companies must cover. If you are going to do business in my State, then you have to provide coverage for these 30 areas that we believe are important.

I note this morning an editorial in the Wall Street Journal that criticizes those of us who have raised issues about this bill. They say in one paragraph:

> Some provider groups are opposed for nakedly self-interest reasons since it would allow plans to bypass state regulations mandating coverage for, say, chiropractors.

Chiropractors provide some decent services to people. But with all due respect, I would suggest that it is a lot more than chiropractors who get bypassed with this legislation. It is things such as diabetes, cancer screening, infant health care, mental health care, pregnancy, Lyme disease, to mention a few. I know several of my colleagues have had family members affected by Lyme disease. My State thinks that is an important area to provide coverage. This bill would eliminate coverage for Lyme disease because this legislation would mandate that Federal law would supersede State law. Regardless of what your State thinks is important, this bill will decide what will be covered. Everything else goes. That is an overreach, in my view. As a result, the analysis of the legislation presented on this chart suggests that in the State of Alabama, 1.7 million people who would be adversely affected if this legislation is passed. In Connecticut, more than a million people would lose benefits that the State legislature requires the insurance industry to cover. In State after State, the numbers are at least in the six-figure category. In California, 12 million people would be adversely affected, Kentucky over a million people, Kansas over a million people, Illinois almost 4 million people, and the like.

I will leave this chart so my colleagues will be able to see how many people will be affected in their States, according to data collected by those who have examined what it would mean to a Federal mandate that tells every State in the country: We don't care what you have done, we don't care what benefits you think are important, this bill will tell you what kind of coverage you are going to have.

We also prohibit the States by preempting their ratings rules, which is my second point. This legislation preempts the States from having rating rules that will actually determine what the difference in cost would be between young and healthy workers and older, sicker workers, to make sure they are not going to price the product so beyond the reach of an older, less healthy person that it would be unaffordable. It is de facto exclusion if you allow the insurance industry to set that price by preempting the States from determining whether there ought to be a cap on how much an insurance company can charge. By limiting benefits and by preempting the States from determining rates and holding them down,

we make it very difficult for literally millions of people to be positively affected by this legislation.

Those are the two major concerns we have. There are other areas that we will certainly raise. I mentioned earlier in my State, more than a million people will lose access to cancer screening, well childcare, diabetes supplies, alcoholism treatment, mental health care, the treatment for Lyme disease, to mention some. The list goes on with my State.

In addition to seeing their benefits disappear, millions of Americans will see their health insurance premiums skyrocket as well. This bill preempts State laws that currently protect older workers, those with serious illnesses such as diabetes, cancer, and heart disease, even expectant mothers, from seeing their premiums increase. This bill will allow the insurance industry to charge people more based on the fact that they are sick or pregnant or simply older.

I have many insurance companies in my State, as my colleagues know, that do a wonderful job in many ways. But don't have any illusions about this. They are going to be offering as few benefits as they can get away with and charge as much as they can. That is what they are in business for. This is not the Vista Program or AmeriCorps. These are private companies. If we give them a green light to limit the benefits you can provide and take the caps off what they can charge, then, obviously, they are going to take advantage of it. I am greatly concerned, as the major business organization in my State warns. When the Connecticut Business and Industry Association says this bill would hurt the businesses in my State, we ought to take note of it. This organization has a strong record of protecting the interests of smaller businesses.

It doesn't take an expert to predict what will happen. Insurance companies are going to offer plans with minimal or no benefits, hoping to attract young and healthy workers. Older, sicker people are going to be left without a plan that meets their needs. Every analysis of this bill reaches the same conclusion.

Listen to what the Congressional Budget Office says. They found the bill ''would tend to reduce health insurance premiums for small firms with workers who have relatively low expected costs for health care and increase premiums for firms with workers who have relatively high expected costs.

In other words, instead of attacking the real problem, the rising cost of health care, this legislation would simply shift costs to small businesses with older and less well workers.

In fact, another study commissioned by the supporters of this legislation concluded this bill ''is not going to address the underlying causes of high health insurance premiums, which are high health care costs.''

Again, Governors, State attorneys general, the State insurance commissioners have all reached the same conclusion, as have an enormous number of groups representing health care providers and patients. All of them say the same thing. They all can't be wrong. When your Governors, attorneys general of the States, insurance commissioners, not to mention almost every single health care group in the country warns about the passage of this bill, then we ought to take note of it. When you hear that you will have literally millions of people losing benefits passed by State legislative bodies that require the insurance industry to cover them, then we ought to take note of that as well.

I know my colleagues will be offering amendments to allow lifesaving stem cell research to go forward, to strengthen Medicaid, reduce prescription drug prices, and ensure access to mental health care. I look forward to having an opportunity to debate those amendments, many of which I will be supporting. We should also consider an amendment to extend the Medicare prescription drug plan enrollment deadline which is causing a huge problem. These are the kinds of issues that ought to be part of our debate today. Medicare beneficiaries have only until this coming Monday, May 15, to enroll in a prescription drug plan, if they are to avoid financial penalty. Why don't we take that as an amendment and extend that time to allow people to come forward. As we are all aware, for many of the Nation's 41 million Medicare beneficiaries, the new prescription drug plan offers more confusion than assistance and, frankly, extending that date would make sense.

I intend to offer an amendment to protect newborns and children from the damage inflicted by this legislation. Right now, 25 states have enacted mandates requiring insurers to provide benefits to the children of their enrollee; 31 States require insurers to cover the cost of childhood immunization.

I am going to ask my colleagues to support language that would see to it that newborns and children are protected in every State, instead of allowing the insurance industry to pick plans that would exclude child immunization and well-child care.

This legislation would completely preempt these State laws, leaving babies and children unprotected. That is a major step backward. Instead, families will be faced with health insurance that doesn't cover routine care for children. They might be forced to pay out of pocket, drastically driving up health care costs, or to forego care entirely. My amendment would ensure that those State laws not be preempted by this Federal mandate that we are about to adopt.

I will also offer an amendment that would prevent health insurers from deciding how much to charge a person for health insurance based on how healthy they are. That is something we have done across the country in State after State.

Many States, including my own, have laws preventing the insurance industry from charging more based on health status. Unfortunately, this legislation would remove those State protections. It would allow the insurance industry to charge more based on health status. We ought to make sure we don't allow that to occur in this bill.

Without these protections in place, it just makes good business sense for an insurance company to increase premiums for people with diabetes, HIV/AIDS, cancer survivors, pregnant women, or anybody with health needs that are outside of the ordinary. As a result, the people who need insurance the most will find they would be the first to lose it.

Finally, I will offer an amendment to protect those patients that admirably choose to participate in clinical trials from undue costs resulting from their routine care. Currently, 19 States, including my own State of Connecticut, have enacted mandates requiring insurers to provide coverage for routine patient care costs while those patients are participating in potentially lifesaving clinical trials. But this legislation, as crafted, would completely preempt these State laws, leaving patients without needed coverage for items such as blood work and physician visits. And this legislation would preempt States like mine that provide benefits for people who are willing to become part of a clinical trial.

Clinical trials save lives. Just 50 years ago, less than one in four women with breast cancer survived for 5 years or more. Compare that to today when 96 percent of women with localized breast cancer reach the 5-year mark. This legislation would create a powerful disincentive to patients weighing the option of whether to participate in a clinical trial. Tragically, we know that only 3 percent of adults suffering from cancer participate in clinical trials. Compare this to the 60 percent of children with cancer that enroll in a trial.

Mr. President, there are a number of amendments we would offer to try to improve this piece of legislation. While I respect the intent of the authors, the bottom line is that it would do great damage to the gains that have been made in State after State across the country, by controlling the costs of premiums and seeing to it that benefits are offered to people out there. The States made these decisions, and the insurance industry, if they want to do business in their States, should comply.

This legislation would mean that the Federal Government would wipe out protection in State after State that has provided for the protection of its people—listen to your Governors, your attorneys general, your health commissioners, insurance commissioners; listen to the groups out there that pay attention to this kind of legislation. Listen to the business groups that have warned what this would do to smaller businesses across the country.

Mr. President, I hope that when the appropriate time comes, we will either adopt amendments that will improve the bill substantially or, more important, adopt the substitute that will be offered by Senator LINCOLN of Arkansas and Senator DURBIN, which would allow people to have the same kind of benefits each and every one of us have as Members of Congress, as part of a Federal health benefit program here that allows for the pooling of people, that would cover 100 employees or less, far beyond what this bill would cover with 50 or less. It would not mandate that benefits provided by States be eliminated, and it would not preempt the States from setting caps on premiums when it comes to older and sicker workers. That is the way to go.

If you really want to make a difference, why don't we adopt this alternative. That would be a major gain for smaller businesses and people who work with them. I understand this is an important issue. Small businesses could use help, but we are not helping them with this bill, with all due respect. We can help them if we take the right steps.

I urge my colleagues to adopt the alternative, or at least improve the bill with the amendments we will be offering in the next few days.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, as I understand it, we are rotating back and forth. Could the Chair tell us how much time we have on this side?

The PRESIDING OFFICER. Nine minutes remain.

Mr. KENNEDY. Well, Mr. President, I thank my friend from Connecticut for an excellent presentation and summation of the principal concerns about this legislation. I ask the Chair to let me know when there is 1 minute remaining.

The PRESIDING OFFICER. The Chair will do so.

Mr. KENNEDY. Mr. President, I thank the chairman of our committee, Senator ENZI, for his diligence in the development of the legislation. It is legislation that I cannot support. But the chairman of our committee has put his finger on an area of health policy, which is enormously important for us to consider, and that is the general kind of challenge that is out there for small businesses in this country. By and large, they pay two or three times higher premiums than many of the very large businesses in their States, and they are also seeing a turmoil in the market.

More often than not, they are changing companies every year, or every other year, and increasing numbers of those small businesses have to drop coverage. This is a real problem.

If the proposal that is before us, the Enzi bill, was only to deal with that particular issue, it ought to be given focus and attention and full debate and support. But his bill goes far beyond that. Fortunately, we have an alternative, as the closing remarks of my friend and colleague from Connecticut pointed out, in the Durbin and Lincoln legislation, which addresses the small business needs. It does it creatively and effectively, and it does it without threatening the health protections that are there for States. The message and word ought to go out to all those who support the Durbin-Lincoln proposal that workers in those small businesses will effectively have the same kind of health care coverage that we have in the Senate of the United States. That has been certainly a goal of mine for all Americans in the time I have been in the Senate, and it still is.

We have an opportunity for the small business community, and for the workers in those companies of 100 or less, to provide for them the same things that we have for the Members of the U.S. Congress and Senate. That statement cannot be made by the Senator from Wyoming. His bill does not do that. It has all kinds of adverse impacts in terms of workers and health care protections.

So as we start this debate, we ought to recognize that there is an alternative which we on this side strongly support which will focus and give attention to the small business community. The other proposal by Senator ENZI does not do that.

Mr. President, I am going to take a few minutes, because that is all I have, to review what I think are the most dangerous aspects of this legislation. The fact is, today, as has been pointed out, there are some 85 million Americans who have protections that will be effectively lost with the Enzi proposal. Those are protections for screening on cancer, for help and assistance in terms of diabetes, for medicines. There are different protections that are given to other diseases that are threatened, and it threatens American families. Those have been discussed in local communities and in States that are now providing those protections; and effectively, under the Enzi bill, those will be prohibited. There are a number of groups.

First of all, this is what the State insurance commissioners say, and why they are important is because they have a responsibility in terms of protecting consumers. This is what they have pointed out, Mr. President:

> Standardizing the rating laws among States will do little or nothing to reduce health insurance costs.

And also:

> S. 1955 will result in older and less healthy employees being priced out of the market as a result of expanding the rate bands.
>
> Small New Jersey employers with older and sicker employees would see a dramatic rise and increase under the Federal approach, effectively driving them from the insurance market and leaving them vulnerable citizens without adequate health coverage.

They are talking about ratings. Insurance companies are going to be able to charge for the proposal that the Senator from Wyoming has talked about. They are going to have a flexibility of up to 26 percent difference—26 times the difference in terms of premiums. Do you understand that? If you are an older worker and have had sickness in your family, you will pay a rating that will be up through the roof.

That is not true in Massachusetts. In Massachusetts, no matter how sick or young you are, you are still within a 3-point or 3 times rating increase. That has worked very effectively. That is something that every older worker, every family that has had some kind of health challenges ought to recognize—that they, under the Enzi bill, could well be priced out of the market.

This is what the attorneys general have said:

> The Health Insurance Marketplace Modernization And Affordability Act should be more appropriately labeled the Health Insurance Cost Escalation Act.

That was the attorney general from Minnesota.

The attorney general of New York said:

> This legislation is not the answer here. It eliminates many of the protections that consumers enjoy, without addressing the underlying problem of cost containment.

They are also eliminating protections, as we have mentioned, for breast cancer and diabetes.

Another one by the attorneys general:

> There are no legitimate grounds for exempting the type of insurance plan for State laws that provide essential safeguards for persons covered by insurance.

It is not just Democrats, but Democrats and Republicans; 41 out of the 50 attorneys general charged with protecting consumers are saying this bill doesn't get it.

Mr. President, this is very interesting by the New Hampshire Governor on S. 1955:

> In 2003, New Hampshire passed a law establishing rating rules similar to those contemplated under S. 1955.

New Hampshire passed almost the identical bill that is now being considered in the Senate.

> With the rules allowing insurance companies to discriminate against businesses with sick workers, or based on geography, this law sent small business health insurance costs skyrocketing across New Hampshire. Small business could not grow, could not hire new workers, and some considered ending their health insurance plans altogether.

They have done it. It is rare around here when you have a new proposal that you have had experience with—and the State of New Hampshire has it—and they ended up withdrawing that proposal.

Finally, we have the various patient groups. Here is the American Diabetes Association:

> S. 1955 would result in millions of Americans with diabetes losing their guarantee of diabetes coverage.

The Cancer Society said:

> Passage of this legislation would represent a retreat in this Nation's commitment to defeat cancer.

The National Partnership for Women and Families said:

Instead of making health care more affordable for those who need it most, S. 1955 would roll back the reforms adopted by many States to require fair pricing.

We look forward on this side to debating these issues—the Durbin-Lincoln proposal and the Enzi proposal—and we also look forward to debating stem cell research, the real Medicare alternative in the prescription drug debate, the ability of Medicare to be able to negotiate lower prices for our senior citizens, and drug importation. If we are going to have a health care debate, let's make sure we are going to deal with many of the issues that people in our country want us to deal with.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. ENZI. Mr. President, as we wait on a couple of people to speak, I would like to make a few comments on the comments that have been made. I do appreciate the spirit in which they have been made. I know there are amendments waiting to modify several of the things that have been suggested, but my biggest concern is that there were some comments about the Attorneys General of the United States and the insurance commissioners who are against it, and even the Connecticut business associations who are apparently saying they are against the bill.

But what I need to correct is the comments they are making are not on this bill. What they are talking about is the bill that the House has passed eight separate times: the associated health plans bill. Associated health plans are different than this bill. It would be nice if some of the people who are going national and public on this would actually check with us on some of their comments to see if they are remotely right.

We have put forward a solution which they said that 85 million people would lose their benefits from. That would be just as ridiculous as me saying that all 27 million people who are uninsured who work for small business would be covered by this bill. Neither of those things is going to happen. There is a medium in there where there will be more people who are insured. The difficult parts that were talked about concerning things being taken away from people I am confident are not going to happen. There are a couple of reasons they are not going to happen.

First of all, there are experiments across the country which in a small way have done what we are talking about in the small business health plans, and in those experiments, they have worked: Taking away the mandates that States have and actually making a point of mandating that we take away the mandates. Around here, ''mandates'' is a bad word. Mandates means you are forcing somebody to do something and you are not paying for it. You are saying you have to have this, and whether you can afford it or not, we are going to make you do it. So your choice is to take the mandate or drop your insurance.

When we are talking about these mandates, a lot of them we are talking about are regular maintenance of your body, and we ought to be having everybody do those. It shouldn't matter whether they are covered by insurance or otherwise. In fact, in Wyoming, we have gone to great lengths to have more things done by public health for free. That means your insurance doesn't have to pay for it and you don't have to pay your insurance company for it and you don't have to pay your insurance company for the administration of that service. But you can get that service. Then we have some other screenings that are covered in a very reasonable way. We have a program in Wyoming trying to get everybody to have mammograms, and it is focused on Mother's Day, which is coming up this next weekend: Get a mammography for your mom. Show that you care. And thousands of people in Wyoming do exactly that.

I will cover some of the other issues, but I see that Senator HATCH, the Senator from Utah, has arrived and has some comments in this regard, and he has been a very diligent worker on all of the small business problems. So I yield time to the Senator from Utah.

Mr. HATCH. Mr. President, I thank my distinguished chairman who I think has done a terrific job on this bill. I understand the distinguished Senator from New Hampshire needs about 3 minutes, so I ask unanimous consent that he be given 3 minutes, and then the time be returned to me.

The PRESIDING OFFICER (Mr. ALEXANDER). Without objection, it is so ordered.

Mr. SUNUNU. Mr. President, I wish to speak to the legislation before us and in particular to address some of the remarks that were made earlier by Senator KENNEDY from Massachusetts. He raised concerns about the State of New Hampshire and suggested that this legislation would be bad for the State of New Hampshire and that the State of New Hampshire had already enacted legislation identical to this. I think it is wrong for someone to provide information that is not entirely accurate. I think that is inaccurate, and it is not inaccurate in some very key areas.

First, the bands that were discussed that were enacted in the State of New Hampshire were much smaller than the rating bands contemplated in this legislation, and they did it in New Hampshire without any transition period. Those are two very significant, specific differences between this legislation and what was attempted in New Hampshire.

Second, as with any legislation, it cuts both ways. There were some employers that saw increases in their premiums 2 and 3 years ago that some claimed were a result of the legislation in New Hampshire, but many businesses—in fact, the NFIB would suggest the majority of businesses—in New Hampshire saw some great relief because they are the smaller businesses that we are talking about, those who would be allowed to improve their negotiating position through the provisions in this bill. Moreover, this isn't a debate about one State. This is a debate about providing increased access—increased access—to plans that are negotiated by associations, by the members of small businesses and, as a result, negotiating lower prices.

Finally, there was discussion about community rating and how objectionable it is that there will be an ability to differentiate on price based on a number of factors. I think the truth is, when you force that kind of price control, you force adverse selection because if I tell you that you have to charge the exact same price to anyone, no matter what region, circumstance, or situation, then the insurer will automatically market to the healthiest people because they won't want to take on the additional costs associated with those who might have significant needs that result in higher prices.

So if you go to price control, which is exactly what the other side is suggesting, forcing the same price for everyone no matter who is covered, businesses will naturally—naturally—only market to those who are healthy and, as a result, reduce the accessibility and availability of health insurance to those who might need it most.

It is a dramatic, unintended consequence, and that is the exact outcome that will be the result of the policies that are being suggested by the other side. We need to be accurate in what we represent. This is a good bill for small business and, as a result, it is an excellent bill for New Hampshire because in New Hampshire, small businesses make up over 95% of all firm with employees. If we want to do something about the uninsured, the majority of whom are working as self-employed or for small businesses, we need to take up the exact kind of provisions that are in this bill: Increased access of health insurance for those working in the smallest firms.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. SUNUNU). Senator HATCH is recognized.

Mr. HATCH. Mr. President, I rise in support of S. 1955, the Health Insurance Marketplace Modernization and Affordability Act. This is a good bill, with good intentions. The lack of health insurance, particularly for employees of small businesses, is a significant problem in Utah and throughout the Nation.

We cannot afford to sit by the sidelines and bemoan this problem, taking little action while millions of American families suffer. The House of Representatives has acted and we should do the same.

Immediately upon its passage though, we were besieged by complaints about House legislation, principal among them the complaint that it overrides State insurance law.

I give the Health, Education, Labor and Pensions Committee Chairman MIKE ENZI a lot of credit.

Chairman ENZI didn't sit idly by.

He studied the House bill, he held extensive hearings, and then he drafted a compromise that resolved many of the concerns expressed about the House bill. This was no easy job.

Immediately, the HELP Committee effort—a solid effort I might add—was besieged by criticism. Much of this criticism I must hasten to add, is not valid.

''It isn't going to cover cancer care,'' the naysayers decry.

''It isn't going to cover diabetics and their supplies,'' they allege.

''It isn't going to cover prenatal care or OB/GYN care for women,'' is a recent complaint.

''It is going to run chiropractors, podiatrists and optometrists out of business,'' say hundreds of form letters that have flooded our offices.

The problem is, these complaints aren't even true. While the standard plan employees must be offered under this bill may not cover all those things, S. 1955 clearly provides an alternative. Employees must be offered an enhanced plan, based on the coverage that public employees receive in the five most populous States, if their employer's standard plan is not consistent with State law.

Most, if not all, of these services would be included in those enhanced plans that employers must offer under S. 1955.

But, let's talk about our basic goal here.

We want to provide affordable health insurance coverage to those who currently do not have coverage.

If we could afford to give them coverage for every possible illness, condition, or procedure, if small businesses could afford to give them coverage for every possible illness, condition or procedure, don't you think it would have been done by now?

Of course it would.

That is the genius of the Enzi bill. It allows a basic level of coverage—perhaps not every single service imaginable, but good solid health care insurance—and for those who want to pay more, there is a plan with more coverage.

In that way, the millions of Americans without health insurance will have access to coverage.

You may ask yourself, ''Who doesn't have health insurance coverage?''

Today, over 45 million Americans do not have health insurance.

Over 25 percent of self-employed individuals are uninsured.

Over 30 percent of people who work for small businesses with fewer than 25 employees are uninsured.

Over 20 percent of the people who work for small businesses with fewer than 100 employees are uninsured.

Something clearly needs to be done.

And that's why we are here, today, debating S. 1955.

I want to illustrate why passage of this legislation is necessary.

Ramona Rudert and her husband, Michael, have owned Professional Automotive Equipment in North Salt Lake for 28 years. They have 12 employees and they offer health insurance to them.

The Ruderts contribute $200 per month to their employees' health care premiums.

Their employees have to pay approximately $500 per month for family coverage.

Their health insurance plan has a $1000 deductible.

So at least there is potential coverage. But here's the kicker: only one of Professional Automotive Equipment's 12 employees decided to be covered by their company's health policy, besides the Rudert family. The rest of their employees cannot afford it.

The interesting twist about this story is that Ramona and Michael have a daughter with juvenile diabetes. They recognize that the basic plan may not cover all the services their daughter needs.

But when asked why she supports S. 1955, Mrs. Rudert replied that she is ''always looking for ways to improve her employees' access to health care'' and that while she has a daughter with Type 1 diabetes, her greatest concern is about the affordability of insurance premiums for her employees.''

Passage of this bill is the top priority for Mr. and Mrs. Rudert, and thousands of Utah businesses. They recognize that affordability is a key component to making that happen.

Let us not make perfect the enemy of the good.

It is an economic fact of life that a Federal requirement for small businesses to cover every small business employee for every possible health care-related service is neither appropriate nor affordable.

Those who decry this bill because it does not guarantee small business employees a comprehensive plan, must be reminded that most employees of small businesses do not have a choice today, if they are fortunate to have health insurance coverage. The legislation before the Senate will create new options for small businesses and, the potential for more choices.

Today, smaller employers do not have the purchasing power of larger employers. If they offer different types of health plans to their employees, the administrative costs of offering these choices are much higher for small employers.

But by leveraging their combined purchasing power, some local small business associations are offering plans that give employers more choice. I believe that similar models could be created regionally and nationally through S. 1955 through regional and national associations.

The goals of S. 1955 are simple. We want to create more affordable health insurance options through choice and competition.

And we want to end the decades-long deadlock and give real relief to America's small businesses and working families.

Who can argue with that?

And small businesses support the freedom to band together across state lines, even without self-funding. Insurance companies support the creation of a level playing field with Small Business Health Plans.

Most important, according to a Mercer study released on March 7, 2006, it is predicted that costs will go down 12 percent for small employers and coverage of the working uninsured will go up 8 percent, approximately 1 million more working Americans.

An added benefit is that the Congressional Budget Office, CBO, believes that passage of S. 1955 will reduce net spending in the Medicaid Program. This is due to the enrollment in employer-sponsored insurance plans of people, who under current law, would be covered by Medicaid.

CBO estimates that enacting S. 1955 would reduce direct spending for the Federal share of Medicaid expenditures by $235 million over the 2007–2011 period and $790 million over the 2007–2016 period. In addition, the bill would result in estimated Medicaid savings to States totaling $180 million over the 2007–2011 period and $600 million over the 2007–2016 period.

CBO estimates that by 2011, approximately 600,000 more people would have health insurance coverage. The majority of these newly covered individuals would be employees of small companies and their dependents.

S. 1955 has been endorsed by a host of organizations: The Small-Business Health Plan Coalition; the National Association of Realtors; the Chamber of Commerce, the National Federation of Independent Business; the National Restaurant Association; the National Association of Manufacturers; the Associated Builders and Contractors; the National Association of Home Builders; the National Retail Federation; the Association Healthcare Coalition; the Textile Rental Services Association of America; the Motor & Equipment Manufacturers Association; the Precision Metalforming Association; the American Council of Engineering Council; Women Impacting Public Policy; National Association of Wholesaler-Distributors; Wendy's International which includes Tim Hortons, Wendy's, Baja Fresh and Cafe Express; Cendant Corporation; American Institute of Architects; Federation of American Hospitals; National Funeral Directors Association; HR Policy Association; Motor & Equipment Manufacturers Association; and the Society of American Florists.

Mr. President, that is an impressive list of supporters.

And I believe that the main reason that we have such an impressive list is due to the leadership of the Chairman MIKE ENZI.

He and his staff did something that the Senate has not been able to do for

over a decade report small business health legislation out of the Senate HELP Committee.

For months, Chairman ENZI spearheaded meetings with the major stakeholders of this legislation the insurance companies, the small business groups, and the insurance commissioners. These meetings produced the bill that we are considering today.

Again, my colleagues may ask themselves, is this bill really needed? Will it truly make a difference?

Just last week a 42-year-old woman from Provo, Utah called my office. Both she and her 9-year-old daughter are diabetics. And she had heard from the American Diabetes Association that S. 1955 would hurt their health coverage.

But as my staff explained the bill's important role in allowing small businesses to provide insurance for their employees, including diabetics, she became very emotional. She recalled how, several years ago, she had her own small business. And buying health care for her employees was forcing her toward bankruptcy. So my constituent had to take away their health insurance. This was extremely difficult for her because she herself had a chronic illness and fully understood the implications. She ended up with an individual health insurance policy. And she found that for the same insurance coverage that she had had in her group insurance policy, she had to pay nearly twice as much.

This happened for two reasons. First, as an individual, she was not eligible for the tax benefit that supports the cost of insurance paid through employers. And, second—because she had diabetes, a chronic illness, her insurance rating caused her to pay significantly more than someone without that disease. There was no risk pool for her to join.

Passage of S. 1955 could have prevented these problems.

I urge my colleagues to think about the health care needs of small business employees in their states before voting on this legislation. This legislation will improve their health care options. Today, they rarely have options when it comes to health insurance and when they do, it is extremely expensive.

Let me conclude by sharing the sentiments of Chris Kyler, the CEO of the Utah Association of Realtors.

Small business owners in Utah are facing a growing crisis with health care availability and affordability. Our profession represents 17% of Utah's gross state product and yet we're arguably the most uninsured working segment in our state simply because we're small business people. As productive contributors to the economy, as a younger, healthier populous, we're supportive of S. 1955 because it will provide us with the opportunity to purchase affordable health insurance.

I believe that Mr. Kyler's sentiments sum up why the Senate needs to pass this legislation as soon as possible. I urge my colleagues to support this legislation so that employees of small business will have access to affordable health care.

I yield the floor.

Mr. ENZI. Mr. President, I yield the remainder of the time to the Senator from Maine.

The PRESIDING OFFICER (Mr. BURR). The Senator from Maine.

Ms. SNOWE. Mr. President, how much time will that be?

The PRESIDING OFFICER. The majority has 9 minutes remaining.

Ms. SNOWE. Mr. President, I thank Chairman ENZI for yielding the time as well as for his leadership in bringing this legislation to the floor, legislation that is so critical and vital to the future well-being of small businesses, I know in my State and across America.

As chair of the Small Business Committee, I know firsthand that this crisis is real. It is an undue burden on entrepreneurs throughout this country, and it certainly didn't develop overnight. Now we have a solution at hand, if we are all willing to forge the consensus necessary to make it happen.

This issue is all the more critical when you consider the fact that today nearly 46 million Americans are uninsured. That is an increase of over 4 million people since 2001. According to the Employee Benefit Research Institute, of the working uninsured, who make up 83 percent of our Nation's uninsured population, 60.6 percent either work for small business with fewer than 100 employees or are self-employed.

There should be no doubt or question that the time has long since come to pass this legislation that will at once assist our small businesses in accessing affordable health insurance for their employees and their families while assuring more of those employees can actually have health insurance.

For this past decade, health insurance premiums have exploded at double-digit percentage levels and far outpaced inflation and wage gains, and Congress has failed to act. Study after study has confirmed beyond a doubt that fewer and fewer small businesses are able to offer health insurance to their employees. Little has been done to alleviate the problem. Quite simply, it has been an abrogation of responsibility.

As chair of the Senate Committee on Small Business and Entrepreneurship, I have held hearings on this question. Small business owners in Maine and across America have consistently and repeatedly begged Congress for relief. They need competition in the market. They need to be able to offer this to their own employees and their families.

That is why I originally introduced the Small Business Health Fairness Act which would have allowed the creation of association health plans to offer uniform health plans across the country, allowing small businesses to leverage their purchasing power on a national basis. This week, for the first time, thanks to the leadership of Chairman ENZI in bringing this legislation to the floor from his committee, the full Senate will be trying to resolve many of the issues, many of the differences of positions and perspectives everybody has on this question.

I thank the majority leader for making this legislation the key component of Health Week in the Senate.

I also thank my friends on both sides of the political aisle, Senator BYRD, who has cosponsored my initiative originally, Senator TALENT, who initiated this effort when he was chair of the Small Business Committee in the House, and the same is true for my predecessor, Senator BOND, when he was chair of the Small Business Committee, for helping to move this issue to the pivotal point where we are today.

I also thank Senator KERRY as ranking member of the Small Business Committee because we also modified my original bill, worked on another consensus bill that would have been a modification based on regional association health plans. I thank him for his effort. Again, that was another attempt to bridge these efforts across the aisle.

But I most especially recognize Senator ENZI's work and his commitment in moving this bill, holding the hearings, trying to reconcile the differences.

This week is not about engaging in heated partisan debate to create issues for the upcoming election. What this should be all about is providing solutions to small businesses and America's uninsured for the much needed relief they certainly deserve.

We are trying to do everything we can to resolve some of the issues. I know there are some concerns, as there were with my initial legislation and as there is with Chairman ENZI's bill now before the Senate. A couple of those issues are, of course, preemption of mandated benefits. I hope to be able to address that question with an amendment so, hopefully, we can reconcile some of the differences across party lines, across philosophical perspectives, so we can get the job done.

There are some concerns about the changes in community ratings. I know that is a particular issue for my State as well. I understand the chairman will address that issue in his managers' amendment.

What we are all here about today is what can we do to address the underlying concern that small businesses have across America. This is a summary of their foremost concern—increasing health insurance costs for themselves and for their employees and their families to the point, as I think we all recognize, small businesses are unable to offer this crucial benefit at a time when they need to be competitive with larger companies because they cannot afford, they simply cannot afford to provide health insurance.

If they can afford it, it is catastrophic coverage, it is a $5,000 or $10,000 or $15,000 deductible at best that

they are able to offer. That is why I introduced the initial association health plans, to give fairness to the market, especially to the small group markets such as the State of Maine. The State of Maine is a small group market and, guess what, there is no competition. No competition means higher prices. Higher prices means virtually no health insurance.

That is why I offered the association health plan. That is why Chairman ENZI is doing what he is doing here today, to try to bridge the differences so we can move and advance this process forward because it is good for all of America.

Small business is the engine that is driving the economy. Two-thirds of the job growth occurring in America today is emanating from small businesses. So it is important to ensure their well-being.

By offering the mechanisms that are proposed in Chairman ENZI's legislation, the small business health insurance plan will help with uniformity as well. Because 50 States have 50 sets of administrative rules, regulations, and mandates, it is virtually impossible to have a uniform standard nationwide. This will allow small businesses to be basically on par with Fortune 500 companies and unions. After all, no one is ever complaining about Fortune 500 companies and unions' plans. In fact, they are the most generous in America. So if they are good for Fortune 500 companies, if they are good for unions, why can't they be good for small businesses? That is what it is all about.

Now people say these associations will not design good plans. If you want to attract members to the plan, if you want people to join your plan, obviously you are going to ensure that you design these plans which will be the most attractive to the greatest number of people who join up in these associations. After all, it is in the interests of small businesses to have attractive plans for their employees because they have to compete with large employers to get good employees, to get skilled employees. If they don't have this crucial and vital benefit, they do not attract the kind of employees they need to make their business successful. That is what it is all about.

I hope we can reconcile our differences through the amendment process, with what I hope to offer as amendments and what others will offer, that can lead us to our goal of addressing the fundamental question for small businesses in America that ultimately will help mitigate the problem of the uninsured that is ever growing in America as well.

As we engage in this debate this week, in the end I hope we can come to a conclusion with a reasonable compromise that will become law. That is what it is all about. I know people have differences of opinion. But I don't think there ought to be a difference of opinion in the final analysis when we address all the issues—the ones that Chairman ENZI addressed to bridge the gap, the ones that my amendment will do, and others might do—which will ultimately get us to the point of beginning to resolve this crisis.

The fact remains that we are seeing fewer and fewer small employers that are providing health insurance for their employees.

If you look at this chart, only 47 percent of the smallest businesses in America—those with three to nine workers—offer health insurance. It is on a declining trend—down to 52 percent, and down to 58 percent in 2002—in sharp contrast to the 98 percent of larger businesses with 200 or more workers that are offering health insurance as a benefit.

For small businesses, things are trending in the wrong direction. Then you look at the small group marketplaces in States such as Maine, which is what this essentially is all about. As we learned from the Government Accountability Office study that Senator TALENT and I requested, Blue Cross-Blue Shield is actually consolidating their market share in a number of States across the country. In fact, 44 percent are in group markets.

I hope we can begin to reconcile these differences and do what I think this Congress can do for the first time that we have had the opportunity to do. Let us not deny small businesses and their employees this one chance to do it. Time has long since passed for action.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Mr. President, before she leaves the floor, I want to express my thanks to the distinguished Senator from Maine for working so closely with me on health care issues. I expect that before long Senator SNOWE and I will be offering our bipartisan amendment to lift the restriction on Medicare that bars Medicare from bargaining to hold down health care costs. Senator SNOWE and I have worked on this for over 3 years. We recently got 54 votes in the Senate to win passage of this bipartisan effort. I thank her for all the good work she is doing in the health care field and look forward to when she offers our bipartisan amendment before too long and to prosecuting this cause on behalf of senior citizens and taxpayers alike.

Mr. President and colleagues, no other health policy in America is more objectionable to the people of this country than preventing Medicare from bargaining to hold down health care costs.

This restriction that bars Medicare from bargaining to hold down health costs simply defies common sense. The restriction that bars Medicare from bargaining to hold down health costs is contrary to what goes on in the private sector of this country every single day. It certainly is contrary to the needs of this program and the taxpayers of this country when we see the Federal budget deficit exploding every time we turn around.

It seems to me that to have Medicare actually barred from bargaining to hold down prescription costs simply defies the sensible approaches that we have always taken in holding down health costs. That approach is to use your bargaining power and the capacity to argue on behalf of large numbers of people. That is using marketplace forces to really make a difference.

The way Medicare is buying prescription drugs under this program is like somebody going to Costco and buying toilet paper one roll at a time. Nobody would ever go shopping that way. Certainly when steel companies, auto companies, any major manufacturing concerns first sit down with a vendor, they ask: What kind of deal will you give me on the basis of the large volume of this product that I am going to be purchasing? Not Medicare. Medicare won't do what everyone else does all across this country every single day.

It is especially important that Medicare use this bargaining power, given what the American Association of Retired Persons has found recently in a report they released to us on the cost of prescription drugs. The AARP released a report in February of 2006 that found brand name medications most commonly used by older people rose almost twice the rate of inflation in other areas of health care.

So here is a chance to actually save money for senior citizens and taxpayers. We can especially expect to see savings when you have single-source drugs for which there is absolutely no competition. There are concrete cases where the Federal Government says we are not going to allow price controls, we are not going to allow the establishment of a one-size-fits-all formulary, but we are going to say that the Government is going to be able to bargain, and that approach will make a real difference.

I know some colleagues think any effort by the Government to allow bargaining to hold down the cost of medicine will lead to price controls. The amendment which Senator SNOWE and I expect to file before long is very clear. It does not permit price setting or the creation of a formulary. All it says is the Federal Government, and in effect the seniors of this country, would be able to go into the market and use their clout just like any other big purchaser could to hold down the cost of medicine using marketplace forces.

As colleagues consider this particular approach I hope—I know the distinguished President of the Senate has a great interest in pharmaceuticals and prescription drugs—that colleagues will look at what Senator SNOWE and I advocate. In that amendment, on page 3, lines 2 through 8 make it clear that we are opposed to price controls. We have continually tried to address this. We are not in favor of price controls. We are not in favor of establishing a one-size-fits-all formulary or instituting a uniform price structure of any kind. All we are saying is that the Federal Government ought to have a

chance to do some hard-nosed bargaining the way everybody else does to hold down the cost of prescription drugs.

Secretary Tommy Thompson, former Secretary of Health and Human Services, said that the one power he wanted as he left office and was denied by the Congress was the opportunity to negotiate when necessary to hold down the cost of prescription drugs.

This amendment would ensure that the prescription drug benefit is sustainable without interfering with marketplace forces and would simply say that the Federal Government could leverage the marketplace just as any other big buyer of a product does.

To date, millions of seniors have enrolled in this program and, of course, they are realizing some savings on their prescription drugs. We are glad to see that, but it has come about primarily through the infusion of taxpayer money.

What I and Senator SNOWE would like to do is bring about some savings—not just by pouring more and more taxpayer money into this program but by using marketplace forces to protect the interests of seniors and our taxpayers.

Prohibiting Medicare from negotiating for drug prices was an overreach. I know of no other industry in the United States that has power like this. We don't see any other industry that does business with the Federal Government in which discussions and negotiations with the Federal Government is specifically barred. Everybody else has to sit down across the table from the Government representing the interests of our taxpayers and get into the nuts and bolts of negotiating the best deal for a particular group of Americans. We need to end this special treatment, this favoritism, this unwarranted preference that only the prescription drug industry has and give our Government the bargaining power that is needed so that seniors and taxpayers can be protected through marketplace forces.

Some who are opposed to what Senator SNOWE and I want to do have said that we are already seeing some negotiations. Of course, that is true. Having voted for this program and wanting to see it work—I have welts on my back to show for that—I am pleased that we are seeing some discussion among health plans and others. But I think we will see a whole lot more opportunity to contain costs and contain them through marketplace forces if we untie the hands of the Secretary, as the previous Secretary of Health and Human Services, Tommy Thompson, sought to do. I believe we ought to take every possible step to save every possible nickel to protect seniors and taxpayers, and lifting this absurd restriction on Medicare bargaining power will do just that.

I cannot for the life of me conceive of a rational reason Medicare should not have the same power to negotiate just the way other smart shoppers do across this country. Every smart shopper in the private sector—every single one—wants the kind of opportunity that I and Senator SNOWE are advocating.

I don't know of any private entity, whether it is a timber company in my home State or a big auto company or anybody else who doesn't sit down across the bargaining table and ask, what are we going to do to work something out that reflects the fact that I am going to be buying a lot of something? Why shouldn't Medicare, if it believes it is warranted, have that authority in effect as a standby?

Senator SNOWE and I have been crystal clear in saying that there is a difference between negotiating and bargaining and price controls and uniform formularies. We would say to our colleagues: Look at our proposal just as we did in the one that received 54 votes recently. We spell it out. We lay it out on page 3 of our amendment, lines 2 through 8. We stipulate no price controls, no uniform formulary, no particular kind of one-size-fits-all price structure in any way.

I would like to, along with Senator SNOWE, offer a market-based, comprehensive cost containment to help hold down the cost of prescription drugs in our country.

I am glad we are discussing Medicare this week. I think it is high time. I tell colleagues that no other health policy in America is more objectionable than the one that prevents Medicare from bargaining to hold down health care costs. It is time to inject some common sense into the Medicare drug benefit. Giving Medicare bargaining power to millions of senior citizens through Medicare is economics 101. If it is important to the seniors of this country, it is important to taxpayers.

We expect to bring a bipartisan proposal to the floor of the Senate this week. We all know we could sure use some bipartisanship around here at this critical time. I hope colleagues will, as they did a few weeks ago, show strong bipartisan support for our proposal. If we are serious about reining in health costs, and the American people say it is at the top of their agenda, you have to lift this restriction that bars Medicare from bargaining. We expect to be filing the bipartisan Snowe-Wyden amendment before long.

We hope, as we did on the last occasion when we voted on this, we will have a strong majority in the Senate in support of a commonsense, practical way to protect senior citizens who are buying prescription drugs and are taxpayers at the same time.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I thank my colleague from Oregon for his incredible leadership on something that makes so much sense, negotiating group prices under Medicare.

Why in the world wouldn't we want to get the best price? Taxpayers want us to get the best price. Seniors want us to get the best price. The disabled want us to get the best price. Why in the world wouldn't we want to do everything possible to have a Medicare prescription drug benefit that offers the very best prices so we can offer as much coverage as possible? One of the things we know, the gap in coverage is partly because we are paying so much for the whole plan. We could give people more coverage and spread it out differently if we were, in fact, negotiating group prices.

I thank my colleague who has come to the Senate floor on so many occasions. He always makes so much sense. I know the people in Oregon are proud of what he has done.

To add to the discussion on Medicare, I am pleased we have Health Week. Even though I will speak at some later time in terms of the concerns I have about the underlying bill, we all chose to vote to proceed to debate on health care because there is nothing more important to the people we represent, whether it is the manufacturers I represent who are having to compete in a global economy and figure how to do that while paying so much of the cost of health care or whether it is small businesses, self-employed people who cannot find coverage at affordable prices, whether it is our seniors or whether it is women and children who need care.

We have a serious issue when we spend twice as much on health care in this country than any other country and still have 46 million people with no insurance, 80 percent of them working.

This is an important debate. Part of that debate, I believe because of the timing, needs to be to address what is happening with Medicare prescription drug coverage. Unfortunately, we are 6 days away from a Medicare prescription drug deadline. Right now, 6 days from now, folks are going to be penalized if they have not signed up for a Medicare prescription drug plan, even though they are having to wade through a lot of information and misinformation in order to be able to figure out what to do, if anything.

I am sure my colleagues have received as many calls as I have received, thousands of calls and letters from people all across Michigan about the trouble they are having related to this Medicare prescription drug program—calls from pharmacists trying to help people figure what to do, spending hours on the phone, being put on hold, unfortunately, receiving inaccurate information too much of the time. We know there are serious issues that have come about because the Government has not gotten its act together, as we should, to be able to present them to people in a way they can understand and make sure it works for seniors and disabled.

We know choosing a plan is extremely challenging and confusing. We have an obligation on our end to do something about that, not wait 6 days and penalize people because they have not signed up for a plan that they may not be able to figure out.

This is not because people are not bright. In Michigan alone there are at least 79 different plans to choose from. Each plan has a different premium, a different copay, covers different medicines. Under the current law, as I indicated before, anyone who does not go through these 79 plans, or whatever number they have in their State, by next Monday will find themselves paying a lifetime penalty, more for prescription drugs than they would if they signed up before then.

A decision about something that is so fundamental to a person's health as their medicine should not be rushed. We should not be scaring seniors into picking a plan that may not work for them because of a penalty they will receive after next Monday. Unfortunately, that is exactly what is happening.

Unfortunately, I continue to believe the ''D'' in Medicare Part D stands for disaster. That does not mean some people are not getting helped. We want people to be helped. We want people who have not otherwise had help to be able to receive it. That is a very important point in this process because the administration has been talking about the 29.7 million seniors who are now covered, seniors and disabled who now have drug coverage under Part D.

But what they are not saying, of the 29 million, 20 million already had coverage. They were covered under Medicaid, they were covered under private insurance, under a Medicare HMO. We are talking about less than 30 percent of those who have not had any help with their medicine, less than 30 percent, have actually signed up so far.

Is it because they do not want help? Of course not. It is because they are having challenges getting through the bureaucracy and trying to figure out what works for them and what does not work for them?

I will share a story of a woman who called me yesterday. This exemplifies the thousands of calls and stories I receive in Michigan. A member of my staff spoke with Shirley Campbell from Midland, MI, yesterday, not far from my hometown. Shirley told my staff about the experience she and her sister had enrolling in Part D. First, they had a terrible time getting through to the so-called ''help'' line.

By the way, the Government Accountability Office says almost 60 percent of the time folks trying to get through to the 1–800 Medicare number are getting incomplete or inaccurate information. That is stunning. We have to get our act together before we penalize people for not signing up for a program.

She kept trying. Shirley kept trying. Once she got through, in response to her question, she was told, ''I can't answer that question because the site is down.'' She did not give up. She called back the next week and she called back the following week. Each time she had the same experience. She could not get an answer to her question because ''the site is down.'' This is the administration's idea of a ''help'' line? It is not much help.

Because Shirley could not get the information she needed from the administration, she called several plans and asked them all to send her their information. Imagine how big that mailbox was. Then she and her sister sat down and spent more than 10 hours sifting through all the information they had received. They narrowed it down to six plans and began a thorough analysis.

What did they find? From the six plans, all of the plans would cost Shirley more than she is currently paying for the medications necessary for her rheumatoid arthritis. Six plans she narrowed it down to, and all of them would cost her more than what she is currently paying. Shirley currently does not have any coverage. Yet she would end up paying more under any of the six plans she studied.

Think of that. We are trying to help people who do not have coverage, and less than 30 percent of the folks who have signed up have been people who did not have help before. Maybe it is because they were like Shirley, when they tried to find someone to help them, they found out they would be paying even more under this privatized scheme that has been set up than they are currently paying.

She also told my staff that most of the plans would have cost her twice as much as she is now paying. But she ended up choosing a plan that would cost her more than what she is currently paying, even though she currently does not have any coverage. She says she signed up because she was worried about the looming May 15 enrollment deadline and the prospect of paying a penalty for the rest of her life.

What sense does this make? Folks are seeing the clock count, 6 days away, until the May 15 deadline and penalty. And Shirley is so worried about what that means down the road, the cost she would be paying and a lifetime penalty, she signs up for a plan that costs her more than she is currently paying. I don't believe Shirley or any senior should be rushed into a premature decision because of an arbitrarily determined deadline. That is all this is. There is nothing magical about May 15, nothing at all.

Shirley worked in middle management all her life. She had the ability to spend hours and hours wading through the plan, the brochures, the paperwork. In the end, she had to make a decision that leaves her worse off than she is today.

Shirley wrapped up her experience of choosing a Part D plan by saying, ''I never in a million years would have done anything like this to my staff.''

She then asked my health legislative assistant to deliver the message to me that the Medicare Part D Program needs to be fixed. Amen. I could not agree more with Shirley.

This is Health Week. This is the time to fix it. The first thing we need to do to fix it is to give folks more time.

I am proud to be joining Senator BILL NELSON on legislation to extend the deadline to the end of the year. If given the opportunity, and I hope we will have the opportunity, we intend to offer that as an amendment, as we proceed with Health Week. People should not be penalized because the Government cannot get its act together. People should not be penalized when almost 60 percent of the time when they call a hotline they cannot get the information they need, it is inaccurate or incomplete. That is not their fault.

The whole point of this was to make sure we were helping people who were choosing between food and medicine, people who were choosing between medicine and paying the rent, the electric bill or gas prices right now. If that is not happening, why are we moving full steam ahead with some arbitrary deadline? Six days from now, folks are going to be penalized because the Government has been slow to get its act together, and they will be permanently penalized by paying more.

Less than 30 percent of the people who do not currently get help paying for their medicines have actually signed up. That should say something. It should either say, it is not a good deal, and they found out they would be paying more, and they said forget it or it says to us that maybe we need to go back to the drawing board and make sure the right information, in the right way, is given out to people so they can make the best decision for themselves.

I am also extremely concerned that in my home State of Michigan only 22 percent of the 256,000 seniors eligible for low-income help, only 22 percent of those whom we said we wanted to help the most by waiving the premium and the copay, only 22 percent have signed up to get that extra help.

Unfortunately, our low-income seniors are caught twice because they have to pick a plan. They have to, similar to Shirley, wade through all kinds of plans. Then they have to sign up separately to be able to get low-income help.

I am pleased the administration has said they will allow low-income seniors to be able to sign up after May 15. I appreciate that. That is a good start. Unfortunately, the penalty is not waived. Our lowest income seniors, even though they may be able to sign up in June, July, and August—and that is a good thing and I appreciate the administration doing that—I urge them to waive that penalty. It makes no sense if you allow people to sign up for extra help and then take it away through a penalty for signing up late.

The final issue is our poorest seniors, our lowest income seniors in Michigan and individuals making less than $14,700 a year, our lowest income seniors or the disabled, in too many instances are actually paying more under this plan than they were before. Why? Because they were on Medicaid before for the low-income health care. In Michigan, that meant paying a $1

copay for a prescription, and that has doubled, tripled or gone higher. This also makes no sense.

On top of that, those who were in Medicaid, our lowest income seniors, many in nursing homes, were automatically enrolled sometime in the last few months, into a plan, regardless of whether it covered the medicines. We have said to the lowest income seniors, many of them in nursing homes, you are signed up for a plan, and you have to go figure out whether it even helps you and how you are going to get out of it if it doesn't help you. And, by the way, you are going to pay more.

We can do better than this. I believe No. 1 is to stop the 6-day count. No. 1, we have to give folks more time to wade through all of this, to figure out what is going on, and we have to give some more time to the Government to get its act together. The administration is doing a disservice to people by the way this has been handled. Giving more time will allow that to happen.

I am also very hopeful we are going to come back and come together and give people the one choice they really want. People do not want 70 plans. They are not saying: Oh, please, give me a whole bunch of insurance papers to wade through. Give me increased premiums. Give me all kinds of deadlines to deal with. What they said was: I need help with my medicine.

We are blessed in this country to have more medicine available as a part of the way we allow ourselves to live healthier lives, longer lives, to be able to treat cancers, to be able to treat other chronic illnesses. Medicines are available now. But they are not available if they are not affordable. We can do better.

Mr. President, I am hopeful at some point we are going to come back to this floor and give people the choice they want: A real Medicare benefit through Medicare, with a reasonable copay and premium, where you sign up and you can go to your local pharmacy, and Medicare negotiates good prices. That is what we ought to be doing.

In the meantime, let's stop the countdown to May 15.

Thank you, Mr. President.

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 p.m. having arrived, the Senate stands in recess until 2:15 p.m.

Thereupon, the Senate, at 12:32 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. VOINOVICH).

HEALTH INSURANCE MARKETPLACE MODERNIZATION AND AFFORDABILITY ACT OF 2006—MOTION TO PROCEED—Continued

The PRESIDING OFFICER. Under the previous order, the time until 2:30 shall be equally divided.

The Senator from North Carolina.

Mr. BURR. Mr. President, I am going to be here numerous times this week. This legislation is too important to have it shortcut. There is not enough time in the debate to say it all at one time.

Last night, this body had the opportunity to vote on proceeding to changes to the liability crisis that exists in health care today, but the minority denied us the ability to move forward. They denied the ability of the American people to hear an honest debate, to consider thoughtful amendments, and then to judge up or down on the content of the legislation.

They had two opportunities: liability that was reform for all medical professionals; and, then, liability that was only changed for those who are OB/GYNs—that next generation of medical professionals who are going to deliver our grandchildren and our great-grandchildren, that profession that is going to regenerate the population of this country and, in fact, is suffering today because of the high rate of liability costs for the premiums they have to have.

Now we are here. We are in debate—30 hours of debate—to see if we can proceed on a bill to bring small business group health insurance reforms into law, to enable small businesses in America to be able to price insurance for their employees in the same way large corporations are able to produce products for their employees.

Today, small businesses' choice is between nothing and nothing. It is not something and something. It is nothing and nothing. And what will we do? We will debate, for 30 hours, whether we should proceed. Some don't believe this is important enough or, if it is important enough, that there ought to be all sorts of changes to it that are unrelated to these millions of Americans for whom their employer cannot afford to provide health care. Why? Because they are not big. The marketplace discriminates because they are small.

Let me give you some statistics about North Carolina. In North Carolina, 98 percent of firms with employees are small businesses. Ninety-eight percent of my employers are shut out of the ability to negotiate a reasonable cost of health care for their employees. Because of that, their employees have a choice between nothing and nothing.

We will have 30 hours of debate to see if we are going to proceed in this body to provide something versus nothing—not something and something. How can anybody object to providing a choice of something for those who do not have an option today?

Additionally, in North Carolina, we have 1.3 million uninsured individuals. And 898,000—almost 900,000—North Carolinians are uninsured individuals in families or on their own with one full-time worker. Those are all individuals who potentially could be covered under an individual or a family plan.

Of the 1.3 million who are uninsured in North Carolina, 900,000 could be affected with this one piece of legislation in the Senate. But for the next 30 hours, we will debate whether we proceed or never get to the process of an up-or-down vote; in other words, it is a choice as to whether we keep them with nothing and nothing and the uninsured numbers stay at 1.3 million or, in fact, we are going to provide something for North Carolina—900,000 people who today have nothing provided for them.

Later today, I am going to come to this floor, and I am going to read for my colleagues real letters, handwritten letters—handwritten letters—from people who live in North Carolina, whose choice is nothing and nothing. These are individuals who have the same health needs, individuals who would like to have health insurance but whose employers cannot afford it today, who want the opportunity in employer-based health care, but because of the way the system is designed today, it is not achievable because it is not affordable for them.

We are here today and tomorrow, and we ought to be here as long as it takes to make sure Americans at all levels have choices between something and something. These 30 hours will determine, in fact, whether this historic institution will provide that for the American people or we will walk away; whereby, once again, the American people will be denied because some in this body do not believe there is a responsibility to move to a point where there is an up-or-down vote. Truly, people can look and say: You have my future in your hands. My health security is in the hands of the Senate, the Members of the Senate, and whether they are going to, in fact, respond to that.

Well, I think people in North Carolina desperately want choice. I think they desperately want this bill. They want their employers to have the opportunity to be able to look at health insurance and to find it affordable. Why? Because that is their security. That is their ability to have coverage.

My hope today is that the outcome of this legislation will not be a quick death such as last night with medical liability reform. We all agree health care is too expensive. We disagree on what the solutions are. But to end up with nothing, to deny the ability to move forward, to deny the ability for the American people's voice to be heard through the amendment process on this floor is disgraceful.

My hope is after these 30 hours we will proceed, we will have a robust debate on the amendments, and, at the end of the day, the American people will have an opportunity for an up-or-down vote in the Senate.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. MENENDEZ. Mr. President, today we are here in the middle of what is being called Health Week in the Senate. But rather than debating important lifesaving, life-enhancing

legislation that has bipartisan support and could actually deliver hope and promise to millions of Americans, the Republican leadership in the Senate has, instead, decided to continue their political posturing, business-as-usual approach to governing.

It is no wonder the American people have become disillusioned with the leadership in Washington. Instead of debating and passing stem cell legislation that will end suffering and extend lives, we are again focusing on a partisan proposal to limit patient options, even when they are harmed, for example, through medical malpractice.

Instead of passing stem cell legislation that will provide new treatments and cures for debilitating diseases, such as Alzheimer's, juvenile diabetes, spinal cord injuries or cancer, we are debating a bill that would actually eliminate—eliminate—the health coverage that many States currently provide to cover some of these very diseases, that will cherry-pick, pitting the healthy versus older workers or those who have some chronic disease or illness. And where there is no insurance regulation, prices go up, insurance companies pick the healthy, and they discriminate against older workers and those who are less healthy.

And they can deny coverage that States have thought important to have to meet the challenges of their individual States, sometimes very uniquely so.

So instead of wasting an entire week debating legislation that I believe ultimately has no chance of passing, we owe it to the American people—to the millions of Americans and their families suffering from life-altering disabilities and diseases—to demonstrate our Nation's full commitment to finding a cure and doing all we can to help their hopes and dreams come true.

It has been almost 1 year since the House of Representatives passed the Stem Cell Enhancement Act, and yet the Senate still has not passed this vital legislation. I rise to urge the majority leader to do the same and bring this important legislation to a vote in the Senate.

I was fortunate to have had the opportunity to vote in favor of the bill as a Member of the House, where we had broad bipartisan support for the proposal. I believe that same bipartisan support exists in the Senate, which makes it even more difficult to understand why we cannot come together and do something meaningful for those who are suffering.

My support of stem cell research is partially a reflection of my home State's commitment to innovation and discovery. In 2004, New Jersey became the second State in the Nation to enact a law that specifically permits embryonic stem cell research. We know that embryonic stem cells have the unique ability to develop into virtually every cell and tissue in the body. And we know that numerous frozen embryos in fertility clinics remain unused by couples at the completion of their fertility treatments. Why shouldn't they be allowed to donate those embryos to Federal research to save lives? We allow people to donate organs to save lives. Why couldn't a couple, if they so chose, donate their frozen embryos instead of simply discarding them?

The great State of New Jersey offers more scientists, engineers, and technicians per capita than any other State, and I am proud to represent the innovation and research taking place in New Jersey. Our State is not only known as the Garden State but also as America's ''Medicine Chest.'' But for our State and our country to continue to compete globally with health care breakthroughs, it is going to take more than private and State support. It is going to take the support of our Nation. It is going to take leadership that looks beyond politics.

But, to me, similar to countless Americans and New Jerseyans, this issue is about more than our ability to compete as a nation. The promise of stem cell research is painfully personal. It means hope and promise—hope that people such as my mother who suffer from advanced Alzheimer's disease might one day be cured from the loneliness and confusion caused by this horrible disease and the promise that future generations of families will not have to see their loved ones enter into a world of dementia that robs them of the best years of their lives.

We hold the key to unlock that door. It is shameful that we have let partisan politics stand in the way of medical progress. We owe it to our parents, to our children, and our grandchildren to unlock that door.

Diabetes, Alzheimer's, cancer, Parkinson's—none of these diseases boast a party affiliation. And we cannot let ours keep us from doing what is right.

Today we have an opportunity to do what is right. But it is clear to me that the majority will again let that opportunity pass them by. I will continue to fight, along with many of my colleagues, to see that this bipartisan bill is debated on the Senate floor and becomes law. We can no longer afford to delay this bill when it holds the key to curing some of the most devastating and debilitating diseases of our day. As the bill waits in the wings of the Capitol, children and adults alike wait for the cure they have been praying for.

This is Health Week. What could better demonstrate our commitment to the health of this country than full Federal support for embryonic stem cell research? This bill has the potential to make a profound and positive impact on the health of millions of Americans. All we need is the leadership to bring the bill to the floor for a vote for the humanity of our Nation and for the mothers, fathers, brothers, sisters, sons, and daughters across this country who are suffering or watching a loved one suffer.

This bill means so much more than ending restrictions placed on stem cell research. This bill means hope and promise to countless Americans.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas.

Mr. ROBERTS. Mr. President, like many of my colleagues, I rise today in support of S. 1955, the Health Insurance Marketplace Modernization Act. As a member of the Health, Education, Labor, and Pensions Committee, I am proud to have worked on this legislation and to lend my support as a cosponsor.

First and foremost, I thank Chairman ENZI and Senator BEN NELSON, who have worked so hard on this legislation. The chairman and Senator NELSON did what many thought was impossible: they got the health insurers, State insurance commissioners, and the small business community to sit down together and work to find a compromise for small businesses. After over 10 years of deadlock, the Senate is finally considering a solution that will provide real relief to small businesses. This is truly a milestone. It has been said before, I am sure many times, that the House has passed this eight times, and we have yet to find a solution. Now is the time.

Like many rural States, the Kansas economy is built on thousands of small businesses. Whether it is the farm implement store or the local pharmacy, the beauty salon or the downtown coffee shop, these small businesses and their employees are the backbone of our communities. They are what we are all about. But one nagging problem for virtually every small business owner is the high cost of providing health insurance. Most small businesses can't even afford to offer health insurance to their employees, forcing many to go without health coverage.

In Kansas, only about 41 percent—not even 50 percent, not even half—of our small businesses offer any health insurance coverage. This is in stark contrast to the 97 percent of our larger businesses that offer health insurance to their employees. Without such health insurance coverage, employees are vulnerable to huge health care debts of their own, and it is harder for small employers to attract a good worker. I have literally heard from hundreds of Kansas small business owners and entrepreneurs, local Chamber of Commerce members over the years who say they are forced to choose between staying in business or providing the health care they deserve to their hard-working employees.

Take for example Kimberly Smith of Andover, KS. Kimberly has three children, including a 3-year-old with a mild heart condition. She is self-employed. She is a realtor. She is a good realtor. Like many, she does not have access to affordable health insurance. Because of this, Kimberly and her family have been forced to go without health insurance coverage, and now she must pay all of her medical costs out of her pocket.

Denise Breason from Lawrence, KS, is also facing the same crunch to find affordable health care. Even though Denise is a hard-working small business employee, she has been without health insurance for over a year and a half and had to stop taking all of her medications because she could no longer afford them without health insurance.

Denise Hulse and her husband went without health insurance for their family for years. They prayed their children would remain healthy so they would not have to make a visit to the doctor or the emergency room. In the end, her husband was forced to let his small business go and take a low-paying job, just because it came with health insurance. To quote Denise:

It is sometimes very hard just making it in the small business community, and very few small business owners are rich enough to be able to afford the high costs of health insurance for their families.

Another small business owner in Kansas told me he is paying over $2,000 a month each month in premiums alone for health insurance for his family. This is more than his house payment, more than his utility bills and grocery expenses, all combined.

These stories go on and on, not limited to my home State of Kansas. I heard these stories when I had the privilege of serving in the House of Representatives. Eight times we approached this issue. Eight times we passed a bill. Now it is our turn in the Senate, and it is long overdue. I hear these stories from small business owners and employees across the country. Small businesses all share one main concern: finding affordable health care insurance.

This is why I am asking my colleagues today to support and pass the Health Insurance Marketplace Modernization Act. The real question is, Do we take it up? Do we vote for cloture? Or do we let the House pass the bill the ninth time while we sit in the Senate and do nothing for those who cannot afford health insurance? I cannot imagine us doing that at this particular time.

This legislation allows small businesses to pool together through an association and offer health insurance. Everything has to have an acronym in Washington. This one does, too. It is SBHP. I won't venture into what that acronym will be called, but it stands for small business health care plan. It is going to give small businesses an affordable choice for health care.

The legislation is built on the fact that small businesses, unlike large companies such as Microsoft or others, or unions, do not have the power to negotiate affordable prices for health care.

The concept of small business pooling together is not new. I supported legislation when I served in the House. In fact, the association health plan legislation has passed the House numerous times over the years without any action in the Senate. Now we finally have a solution that will provide meaningful relief to small businesses across Kansas and the country. We all know small businesses face many pressures in running the businesses. I believe we must enact commonsense policies to overcome these hurdles. We should allow the local farm implement dealer to pool together with other dealers in Kansas and across the Nation to purchase affordable care.

Kimberly Smith should no longer have to worry about finding affordable health insurance for her children. Denise Breason should not have to stop taking her medications just because she works for a small business and cannot afford her care. Denise Hulse and her husband should not have been forced to let go of their small business, their dream they loved, just to find affordable health coverage. Instead, we need to find these hard-working folks affordable options that allow them to continue to contribute to our small communities, rural and smalltown America. This is why I support the legislation.

As I stand before my colleagues today, I know there have been strong concerns expressed about this and previous association plan proposals. However, the small business health plans that are created under this bill have the necessary protections in place to address these concerns. I would like my colleagues who have concerns to please pay attention.

The small business health plans will be regulated by the States, not the Federal Government. The small business plans will have to play by the same set of rules as other small group health plans. They must purchase their insurance through the regular insurance market. They cannot self-insure. Finally, the SBHPs may offer coverage that varies from State benefit mandates, but they must also offer an alternative plan that provides comprehensive coverage. This gives the consumer a choice in choosing a health plan that best fits their needs, and that is the key.

I have heard concerns from organizations and individuals who fear this bill will take away their coverage for cancer screenings, mental health benefits, or any other mandates required by State law. However, I stress that this is simply not true. Small business, under this bill, will have access to a more comprehensive plan which will cover screenings, mental health services, or numerous other benefits. However, it is up to the small businesses to decide whether such a comprehensive plan is right for them.

The purpose of this language is to give small businesses the option of choosing comprehensive benefits but not requiring them to buy such a rich package or a package they cannot afford. Simply put, this legislation trusts small businesses to choose a health care plan that best fits their needs and puts these small businesses, not health insurers or the Government, in the driver's seat when choosing their health care coverage. If a small employer wants to choose a more affordable plan for himself, his family, and his employees, he should have that option. Under this legislation, he has that option. However, he should not be forced by law to buy benefits that may be beyond what he can afford or beyond what he and his employees really need.

I want to put the problem of mandating coverage in perspective. While small employers want to provide affordable health insurance for their employees, expensive and burdensome benefit mandates make doing so very difficult. Small firms and self-employed people have almost no leverage with insurance companies. In addition, they have to deal with an enormous array of State-level health insurance regulations. I don't think you read them; I think you weigh them. All of the benefit mandates, all of these regulations add to the cost and the complexity of the coverage.

In contrast, however, big businesses generally don't have to deal with burdensome regulations. Federal law lets large companies, such as Microsoft and GM, and unions bypass expensive State benefit mandates to provide affordable comprehensive coverage for their workers. I ask my colleagues, why shouldn't small businesses be able to enjoy these same opportunities?

Today, there are more than 1,800 State mandates, making it nearly impossible for associations to offer uniform and affordable benefit packages on a regional or national basis. Taken together, these benefit mandates create a confusing web, an unfunded mandate that prices many Americans out of the health insurance market. The Congressional Budget Office and the Government Accountability Office and others have found that State-imposed benefit mandates raise the cost of health insurance anywhere from 5 to 22 percent. In addition, CBO estimates that every 1-percent increase in insurance costs results in 200,000 to 300,000 more uninsured Americans. In reality, benefit mandates represent an unfunded mandate on employers because insurance companies simply pass the cost of each mandate along. When the cost goes up, the coverage goes down. You have more uninsured.

The legislation we are debating today simply provides an opportunity for a small business health plan to relax these burdensome mandates to offer affordable health insurance to small businesses on a regional or national basis, just like the big businesses and unions currently do. We should not be forcing small businesses to choose between staying in business or offering health insurance to their employees. Boy, that is a Hobson's choice. Instead, we need to give them more affordable health insurance choices and be willing to trust them to choose the option that makes the most sense for themselves, their families, their employees, and the future of their businesses.

I know this bill is not perfect. Seldom do we or the other body pass a bill that is perfect. I have long said that we usually achieve the best possible bill, but sometimes must settle for the best bill possible.

I appreciate the concerns that have been expressed with this legislation. However, I express to my colleagues that I think this bill is the best opportunity we have for easing the burden on our small businesses and allowing them to finally offer affordable health care insurance to their employees. I am proud to support this legislation. I urge my colleagues to do the same and vote for cloture. Eight times in the House, zero in the Senate. That should not be a moment of pride for this body. Let us vote for cloture and let us support this bill.

I yield back my time.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized.

Mr. GREGG. Mr. President, I rise to associate myself with the remarks of the Senator from Kansas, and especially with the efforts of the Senator from Wyoming who brought this bill to the floor of the Senate. This is a very significant piece of legislation in our efforts to try to make sure more Americans have the opportunity to get fair, affordable, and good health care insurance. It is a piece of legislation about people. It is directed at people who work in what is termed ''small business.'' That is the person who works as a cook in a local family restaurant or a person who works as a mechanic in a garage or a person who runs a mom-and-pop real estate agency.

Literally, there are tens of thousands, millions of these small entrepreneurial centers throughout this country. Most of these folks don't make a great deal of money. They work very hard. They are taking care of their families. One of their biggest concerns is whether they can get health insurance so if somebody should get sick who works with them or should somebody in their family get sick, they will be able to have adequate care. But too many of them are not able to afford health insurance. Approximately 22 million people who are in these small businesses, these small retail businesses, small manufacturing businesses, small entrepreneurial shops, don't have insurance. Another 5 million people, who are sole proprietors and work by themselves, do not have a number of employees working with them, also don't have insurance. That is 27 million people who fall into this category. So Senator ENZI has brought forward a bill to try to address that problem. It is going to try to make it possible for these people who work so hard and who would like to have insurance policies that are affordable to get them. By allowing them to band together in trade groups, so realtors can come together, as well as automobile dealers, garage owners, restaurant associations, and hotel associations can come together and form a large enough group so that they can create enough of a mass of interest and buying power so that they can go out and purchase insurance. That is something they cannot do today as individuals. This bill allows them to do that.

It is hard to understand how anybody could oppose this concept. But people do oppose it, and I think most of the opposition comes from folks who either misunderstand the bill or who are using the bill as a way to energize their constituencies with information that is at the margin of believable, to be kind. The biggest opposition today to this bill, other than insurance companies who might see this as a competitor, comes from these groups that represent various different diseases and have compelling stories to tell about their diseases. They have gone to the State legislatures and they have gotten them to put in place what is known as mandates so any policy sold in that State has to cover that disease.

As was pointed out by the Senator from Kansas, every time that happens that increases the cost of the insurance in that State. For every 1 percent increase in the cost of insurance—and some of these specific mandates are expensive enough so they by themselves represent a 1-percent increase in insurance premiums. But there are 200,000 to 300,000 people who cannot afford insurance because the insurance bills go up and 200,000 or 300,000 people fall off the rolls.

What this bill tries to do is address the issue of the person who has fallen off the rolls, the person who hasn't been able to get the insurance, by giving them an option that they can buy, which they feel is adequate to their needs—it may not have a specific mandate in it because maybe they don't need those mandates to be covered, but at least it gives them the basic coverage they need in order to get through their health insurance risks.

The flip side of this coin, which isn't talked about much but which is fairly obvious, is that these people have no insurance at all. When these mandate groups argue, if you pass this bill, you are going to undermine the capacity of people to get insurance for this disease group, that is a totally misleading presentation because the people this is focused on don't have insurance to begin with. You cannot take something away from somebody who doesn't have it. If a person doesn't have an insurance policy, he doesn't have the mandates that the insurance policy requires.

If a cook working in a restaurant or a garage attendant working at a gas station or a realtor working in a small mom-and-pop real estate agency doesn't have any health insurance, you cannot take away from them mandated coverage for health insurance because they don't have it to begin with.

What this bill tries to do is allow that individual to participate in a group where they will have health insurance as an option. And if they have that option of health insurance, without mandates, they also have to have—that group, that restaurant, that real estate agency, that garage the option to purchase a fully mandated policy. In other words, it is a policy that is, for lack of better terms, a higher option policy, where you have everything covered. It has to track the five States in this country which have the most mandates on their insured. So the bill is balanced in that area of mandates.

A second opposition to this bill has been the fact that it moves from community rating to a banding system. What does that mean? It essentially means that on a community rating you basically force everybody to be rated the same, no matter their health risk or age group or occupation. With a rating system, you adjust marginally for what health experience it may be or what age it is. Adjustments can be made, but they are limited by the State. If you have a community-rated system, you inevitably have a much higher cost going in for a lot of those people who are banding together in groups, who maybe don't have as much risk as others. But if you have a rating system, some people are going to be lower in insurance costs and some people will be higher. They are going to be within a relatively narrow band.

So this bill allows these policies to be offered with a rating system, with a band. In New Hampshire—and this has been referred to on the floor by the Senator from Massachusetts—they had a very bad experience because, regrettably, New Hampshire did it the wrong way. We had a community rating system and then we went to a band rating system because we recognized that was better policy. I congratulate the State for that, but they didn't go to it correctly. They went sort of cold turkey. The practical effect was that one day people got one type of bill, and the next day they got a different type of bill. For some people it went up, for some people it went down, and it was a rather startling event for them. We looked at that experience in committee and said we don't want to emulate what happened in New Hampshire. We want to make this a much more responsible approach. We put into place a glidepath, 5-year phasing, so there will be plenty of time to adjust and to be able to handle this.

That type of opposition to this bill, clearly, in my opinion, has been addressed. It has been addressed specifically because of the New Hampshire experience. So it is a misrepresentation to say that continues to be a major issue with this bill. As a practical matter, there are about 85 million people in this country who work in small businesses. That is a huge number. They deserve the opportunity to have this type of insurance made available to them. They should have the same opportunity as big businesses—the IBMs,

the Microsofts, the major manufacturers—in our country, if for no other reason than they happen to be the engine of economic activity in this country. Most of the new jobs are created by small businesses, the moms and pops who are willing to build that restaurant, take on that exciting opportunity, start small and grow. When they do that, they ought to have the opportunity to also have an insurance option available. But many of them don't because it is not affordable, because of the way the States work the system, and because of that these small groups, as individuals, have no buying power. So this bill has addressed that need.

It is not the answer. This isn't a magic wand, but it is another opportunity put on, let's say, the cafeteria line of insurance that gives a small businessperson the chance to go down that cafeteria line and say: Yes, this plan works for the five people who work for me, and I am going to buy into the plan because I can afford it. Today, most people who walk down that cafeteria line, if they are small businesspeople, don't choose anything because they cannot afford the price of anything, or many of them are in that capacity, that 22 million. This will take a fairly significant number of those folks and give them the opportunity to purchase health insurance.

So it will take people from a noninsurance status to an insured status, from a situation where if they get sick, they don't know how they are going to pay for it, to a situation where if they get sick, they will have coverage. It is very important financially to most people and, obviously, it is important psychologically to everybody. So it is a good bill, something we should support.

I do think much of the opposition to it is misguided because it doesn't recognize that the basic goal is to take people who don't have insurance today and get them insurance. Therefore, the arguments around mandates are irrelevant to that group of people and the argument of community rating as I think we will address.

I congratulate the Senator from Wyoming for bringing this bill forward. I look forward to working with him on this bill.

I want to speak on another matter briefly because there is a lot going on that is very good in this country relative to the economy, and it is not being highlighted.

Today, there was an editorial in the New York Times that said we should not extend the tax cuts put into place in 2003. They say those tax cuts should not be extended in the areas of capital gains and dividends. That argument is good in 1930s economics. It is the old left theory of tax policy, which is that you increase revenues by constantly increasing taxes on people. It has been proven wrong this year, last year, and the year before. It was proven wrong by John Kennedy when he put in place the first tax cut. It was proven wrong by Ronald Reagan when he put in place the tax cut of 1980. And it has been proven wrong again.

In fact, in the first 6 months of this year, tax revenues jumped 11 percent, $134 billion, and a large percentage of that is the increase in tax revenues from capital gains and the fact that we have reduced the rate on capital gains which causes people to free up assets. Over the last 3 years, revenues have jumped dramatically—in fact, last year by 14 percent, and the year before by 7 percent, and next year they are projected to jump again. Why is that? It is because we are seeing an economic boom which has created 5.3 million new jobs since those tax cuts were put into place. There have been more jobs added in the United States in that period than Europe and Japan combined have created. And those jobs have led to economic activity and, in turn, have led to revenues to the Federal Government.

Revenues to the Federal Government are dramatically increasing because the economy is growing, and the economy is growing because the burden on those people who go out and are willing to take risks through capital investment, dividend activity, through income tax activity—those people are taking risks and creating economic activity and, as a result, creating jobs which, in turn, create taxpayers, which, in turn, increases the Federal revenues.

The numbers don't lie. They are huge, significant, and they confirm, once again, that John Kennedy was right, Ronald Reagan was right, and George Bush was right. By making tax rates fair, especially on capital formation, you energize economic activity and, in turn, you create massive increases in Federal revenues. Regrettably, I must say the New York Times is wrong.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Arkansas is recognized.

Mrs. LINCOLN. Mr. President, I am so happy to come to the floor today because the Senate is finally debating how we can help small businesses across our country afford health care for their employees. Just as Senator GREGG has mentioned how important it is to provide benefits to groups who want to invest, and to individuals and companies who want to invest and grow the economy, so too it is critically important that we provide small businesses the ability to invest in themselves. That is what I want to talk about today.

Small businesses are critical to this country. They are critical to rural States such as mine in Arkansas, but they are the engine of our economy in this great Nation. They are the No. 1 employers. That is why it is so important that we get this right, that we provide them with a tool that will allow them to reinvest in themselves and their employees and their communities, so that we can keep that engine going.

I applaud my colleague from Wyoming, Senator ENZI, for all he has done in bringing about this debate. He has worked hard and genuinely on this issue, and I appreciate very much what he has put into this. He has helped us make sure this is not a debate about whether this is a critical issue.

This reminds me of something I was taught by my father who said: If it is worth doing, it is worth doing right. It is worth doing correctly. That is what we are here to talk about today.

I believe very strongly that our small businesses are so important to us—our self-employed individuals in this country have the greatest spirit in the world—and it is so important that we should not offer them a second-rate opportunity. We should offer them the same opportunity we have as Federal employees and Members of Congress: The opportunity to build a pool that will offer them greater access, greater choice at a lower cost, by pooling all of themselves together across this great country, while maintaining the quality, which is what we do for ourselves. We maintain the quality of the product of the health insurance we receive or have access to as Federal employees and Members of Congress, and we should do no less for the small businesses and the self-employed individuals in this great country.

So I hope, as we continue this debate, we will remember those hard-working American families who are depending on us not just to do something, but to do what is right and fair, and offering what we see as fair tax policy and offering what we see as fair access to the same quality product of health care and health insurance that we as Members of Congress get.

The small business health care crisis is undoubtedly one of the issues I hear the most about when I return home to Arkansas. In fact, in every community in our Nation, as well as millions of working families across this country, we are seeing the difficulty of having access to quality health care and health insurance and the ability to pay for that.

There are approximately 46 million Americans currently without health insurance, including 456,000 Arkansans whom I am responsible for in terms of producing a product that is worthy of those individuals. Small businesses are the No. 1 source of our jobs in Arkansas. Yet only 26 percent of the businesses with fewer than 50 employees offer health insurance coverage. Workers at these businesses, which again are the engine of our economy, are most likely to be uninsured. In fact, 20 percent of working-age adults are uninsured in Arkansas. This number is alarming, and addressing this problem should be a national priority, and we should approach it as if we are going to do the best job that we are capable of doing. That is why we are here today, to talk about that.

Mr. President, 224 major organizations are opposed to the proposal that

Senator ENZI has brought before us. Two hundred-and-twenty-four is a huge number: everywhere from diabetes to mental illness to hospital federations. These individuals understand how important the years have been in allowing State insurance commissioners to be able to set mandates in order to cover what is important to individuals in their States, and what is important to small businesses and everyone in those States. Those States have the right and the ability to figure out what is important to them, and the majority of them have agreed on many of these major issues.

Those who lack health insurance do not get access to timely and appropriate health care. We know that, and we see it. We see it in the cost of Medicare when people don't get health care for 20 or 25 years when they are in the working marketplace as a small business owner or employee, and then they become more costly to us when they hit Medicare age because they haven't received the screenings, the timely visits to the doctor, and they haven't been getting the kind of health care they truly need. They have less access to these important screenings. They don't have access to the state-of-the-art technology that exists or prescription drugs, which is another piece of what can help keep down the cost of health care.

Working families need help with this problem. The Institute of Medicine has reported that 18,000 people die each year because they are uninsured. The fact is, being insured does matter. It makes a big difference. It makes a difference in our health care costs. It makes a difference in whether you are going to survive—longevity, the ability to care for your family. It makes a big difference. We have reached a juncture where we are going to debate how we deal with those who are uninsured, whether we are going to give them substandard coverage or whether we are going to give them the coverage that we have.

Again, I commend my colleagues, Senator ENZI from Wyoming and Senator NELSON from Nebraska, for their leadership. I appreciate their hard work on this issue. But I do disagree, because I believe that the devil is in the details on this issue, and I am deeply concerned about the very harsh and unintended consequences that will occur if S. 1955 were to become law.

Senator DURBIN and myself have been working together for several years to come up with what we believe is a better health care plan for America's small businesses. What we have done is looked to a 40-year-old tested delivery system, and it is the one that we ourselves use. It is a Federal plan that takes the best of what Government can do and combines it with the best of what private industry can do. The private marketplace and the competition that it can create allows the Government to pool all of its Federal employees and use that pool as a negotiating tool to bring us greater choice at a lower cost.

About 3 years ago, I suppose it was, my staff and I were discussing the way we could help small businesses, and I thought about the way my Senate office operates. It operates much like a small business in my home State and here. As I looked at my employees, I saw that I had two employees, one with 26 years with the Federal Government, another with 30 years with the Federal Government. I had two women who had delivered babies and were on maternity leave. I had some, such as myself, with small children and a husband that is on my plan, and then I had a host of young, healthy staffers who were single. But I had a whole array of different individuals who needed a tailor-made insurance plan for their needs. While there are similarities in our Senate office and small businesses, there are also some obvious differences. One of the most glaring contrasts is access to affordable and quality health care. I saw what my office went through and realized that is what small businesses are going through. I knew we could do better. I knew we could take the plan of what we have and apply it to small businesses.

Last year, more than 8 million people were banded together in the Federal employees purchasing pool, and that gave us choices among 10 national health insurance plans and a variety of local insurance plans, and a total of 278 private insurance plans from the private marketplace. Not government-run—not government-run health care at all—but health care from the private industry, health insurance from the private industry that was created by competition of the multiple Federal employees across the country. It offered us greater access, greater choices at a lower cost.

So I am here to ask this question: Why don't we try to give small businesses access to that same type of private health insurance option that Members of Congress and Federal employees enjoy today? Rather than reinvent the wheel, why don't we create a program for small businesses that is based on our Federal Employees Health Benefit Plan, through the FEHBP, by pooling them, the small businesses, together in one nationwide pool. That is exactly what Senator DURBIN and I have proposed in our Small Employers Health Benefit Program. By pooling small businesses across America into one risk and purchasing pool similar to the FEHBP, our program will allow employers to reap the benefit of group purchasing power and streamline administrative costs as well as access to more plan choices. The SEHBP, as we have introduced, lowers costs for small businesses in two key ways: It pools them into one national pool across the country, therefore spreading the risk between the healthy and the sick, the young, the old, those who live and work in the remotest parts of this great land and those who work in the most urban areas. Second, our plan significantly lowers administrative costs for small businesses.

Two economists have estimated that SEHBP would save small businesses between 27 and 37 percent annually, even if they don't take advantage of the tax cut that we offset costs with by insuring lower income workers. We provide a tax cut to small businesses, and for the life of me, I can't figure out why those on the other side of the aisle, for the first time I have ever noticed, will fight a tax cut for small businesses. Providing small business a tax cut to be able to engage in what is such an important tool in getting themselves and their employees insured makes good sense. What a great investment.

Senator GREGG was talking about balancing all of that and the economy. What a great way to balance what corporate America gets and their ability to deduct health insurance costs that they have and small business getting a tax cut for investing in their employees and health benefits for them. Under our bill, employers will receive an annual tax credit for contributions made on behalf of their workers who make $25,000 per year or less. And if the employer contributes 60 percent or more to the health insurance premium of an employee making $25,000 or less, the employer will receive a 25-percent tax credit. And the tax credits increase with the number of people covered and the proportion of premium the employer chooses to cover. Also, the employer receives a bonus tax credit for signing up in the first year of the program, because we know from the example of the Federal employees that the more employees who are in the pool, the greater advantage to everyone concerned. Small businesses will save thousands of dollars—even more—under our plan.

Segmenting the market into different association pools, as S. 1955 does under Senator ENZI's bill, will not achieve these savings that would be created by instituting one large pool with all of those small businesses and self-employed individuals. Each association will be administering to a separate group with a different administrative structure and different costs, obviously. More funds would be going to administrative costs as opposed to serving the people with a quality health plan. Our SEHBP would have one administrative structure and could pool approximately 53 million workers together, therefore balancing the risk of sick and healthy, young and old, rural and urban, for affordable rates for everybody. Why wouldn't we want to make our pool as big as it possibly could be, as we do with the Federal workers?

I believe our plan takes a real moderate and balanced approach that combines the best of what Government can do with the best of what the private sector can do, and preserving important coverage for preventive health

care treatment such as diabetes supplies, mammograms, prostate screening, maternity and well-baby care, immunization, things that States themselves have decided are important enough to mandate coverage for and ensure that the people of their State are going to get the safe and important coverage of illnesses that are critical to them in their State.

Like the FEHB Plan, our program does not promote Government-run health care, but it harnesses the power of market competition to bring down health insurance costs using a proven Government negotiator in the Office of Personnel Management, OPM, which is the negotiator for our plan. We, once a year, as Federal employees, can choose among 270-plus plans. We are able to actually benefit from that proven Government negotiator and the harnessing of that power.

Our legislation, S. 2510, has been endorsed by many organizations—the National Association of Women Business Owners, Small Business Majority, the American Medical Society, the American Diabetes Association, the National Mental Health Association, the Cancer Society, and many more that have realized how important it is to use a proven example, a proven structure that maintains quality but helps by pooling and bringing down those costs.

The Mental Health Liaison Group, representing over 35 national mental health organizations, wrote to us and said about our bill:

S. 2510 does not sacrifice quality of coverage for affordability or allow the offering of second class health insurance to small businesses. Within the FEHBP program, small business owners, employees and their family members would be covered by all the consumer protections in their home states—including hard-won state mental health parity laws and mandated benefit laws.

The American Academy of Pediatrics, writing to us on behalf of over 60,000 primary care pediatricians and pediatric specialists, wrote:

Through the benefits of pooling small businesses and providing tax cuts to small employers, small pediatric practices will be assisted in the health insurance market without sacrificing health care services for children.

The American Diabetes Association wrote to us and said:

While other proposals seeking to provide health benefits for small businesses . . . have exempted or eliminated coverage for important diabetes care protections, [our bill,] S. 2510, will allow individuals with diabetes to receive the important health care coverage they require to remain healthy and productive members of the workforce.

This is not just about quality of life, although many of us believe that is very important. We as Members of Congress enjoy a quality of life because of the very healthy health insurance program we are offered. We want our small businesses that are vital to our economy to enjoy that same opportunity. But it is also about economics. It is about making sure we keep our workforce, particularly our small businesses and their workforce, healthy and thriving and productive and in the workplace. It is about making sure America's working individuals and working families get the health care they need before they reach 65. When they hit 65 in the Medicare Program, then they are going to be more costly to Government because they are not going to have gotten the health care they needed and deserved in their working years.

I believe our plan is better in so many ways. I am proud we are having this debate, and I hope so many people will realize we can do better. We can do better and make sure we truly elevate small businesses and self-employed people to the same level we hold ourselves, in providing them the access to the same quality type of health care.

Our SEHBP bill offers tax cuts for small employers. Senator ENZI's bill does not. SEHBP relies on a proven program. It is based on the successful Federal Employees Health Benefit Program which has efficiently and effectively provided extensive benefit choices at affordable prices to Members of Congress and Federal employees for decades. For decades, we have had a proven program out there that proves you can harness the competitive nature of the marketplace, and with the oversight of Government and the State mandates, you can actually provide that quality of health insurance at a lower cost. By pooling small businesses together and allowing OPM to negotiate with private health insurance companies on their behalf, they, too, could have access to this wide variety.

On the other hand, Senator ENZI and Senator NELSON's bill establishes a new set of responsibilities at the U.S. Department of Labor, to administer an untried and an untested program. We don't reinvent the wheel. What we do is use what already exists. To invent a new section of the Department of Labor to administer Senator ENZI's bill is going to take time and money. We are not going to know how it needs to be administered through the Department of Labor. They have never done it before. Even the Department of Labor employees currently enjoy benefits from the health insurance program that is negotiated by the Office of Personnel Management. So it is hard to believe they are going to want to go to another system.

SEHBP offers individual self-employed workers the same access to health insurance that is offered to group businesses. SEHBP defines small businesses as groups of 1 to 100, so an individual self-employed person will be treated exactly as a business with 2 or more people. Any business with 1 to 100 employees is eligible to participate in what we are trying to do.

Under Senator ENZI's bill, the self-employed people are not pooled with the small businesses, unless they are mandated by State law. And there are not that many State laws that actually mandate that. But the self-employed people in 36 States, including Arkansas, will not have access to the same negotiated rates of businesses with 2 or more people. They will be pulled out of that pool and rated on their own. That means, if they are younger women of childbearing years or perhaps they are older workers at 50 or 55 and are diabetic, they will be rated completely separate from the pool, which means they will be segregated and treated differently. They don't get to enjoy the benefit of a larger risk pool which could bring down their costs and offer them greater choice.

Our bill also ensures access to health care specialists. Many States have passed laws requiring insurers to cover certain health care providers, including dentists or psychologists or chiropractors. All three of these and many more are required by our State of Arkansas law. I know the people of my State enjoy the assurance they have of knowing that their State regulator, their State insurance commissioner, is looking out for their needs. They can do that better on a State level. That is why we have always left those types of regulatory issues up to our State—because they know and can work.

Can you imagine being a small business, or better yet an employee of a small business, having to call some big, huge, Federal bureaucratic office to request or to complain or to have your concerns heard about what is not covered under your insurance plan? No, they call the State insurance commissioner today, and that is the way it should be. The State insurance commissioner can then respond to the concerns of their constituency and has done so very well over many years.

The coverage for diabetes supplies, mammography, and other important screenings are mandated by State law which would be preempted by what Senator ENZI is trying to do. Many States have passed laws requiring health insurance companies to cover these benefits because insurers simply were not doing it. It did not happen because the insurance commissioners just decided on a whim to do it; it is because the insurers were not covering it. Why do we have to go back and relearn that lesson?

For 40 years, the Federal Government has used the effectiveness of the pool of the 8 million Federal employees and been able to enjoy the protections that are there, guided by State insurance commissioners.

Our bill also prevents unfair rating on gender and health status. Under our bill, health insurers will be prohibited from ratings based on health status—whether you happen to be diabetic, whether you happen to have eating disorders—your gender, or the type of industry in which the employees are working. Under Senator ENZI's rules, that will be all preempted, even for the 15 States that don't allow ratings on these factors.

Our bill also frees employers to focus on running their businesses. They don't

have to go and negotiate these plans through their association or with their association. They are going to get sent a booklet just as we do, once a year, to review all that is available to them, and choices, and then figure out what is best for them. My employees—each of them picks something different. I pick coverage for a family with children. Some of them pick a PPO or an HMO. Some of them pick all different kinds of State plans and others that are offered to them in that process.

Mr. CARPER. Will the Senator yield?

Mrs. LINCOLN. Absolutely.

Mr. CARPER. Mr. President, how much time is left on our side during this period of debate?

The PRESIDING OFFICER. There is 5 minutes remaining.

Mr. CARPER. How much longer does the Senator expect to speak?

Mrs. LINCOLN. How about if I just go ahead and yield to the Senator from Delaware because as a former Governor, he has some incredible stories to tell, and I think they really add to this debate. I will simply say to my colleagues that I hope they follow this debate very closely and certainly appreciate how important this is to the working families of all of our States.

Mr. CARPER. I thank my colleague for yielding. I ask if she would stay on the floor.

I commend Senator LINCOLN for actually coming up with this idea. It is an idea for which she and Senator DURBIN share credit. When you think of some of our options, the options basically are do nothing, maintain the status quo, continue to make the cost of insurance very steep and rising for small businesses or to adopt the proposal of our colleagues, Senator ENZI and Senator NELSON, whom I believe are two of the most thoughtful Members of the Senate. They have worked hard to try to make a not very good idea—the original association health plan—a better idea. But between doing nothing and the modified HP legislation from Senators ENZI and NELSON is a third way. The third way has already been outlined here by Senator LINCOLN.

I wish to ask my colleagues to think about it. I don't care whether it is a Democratic idea or Republican idea. It is actually an opportunity to take the best from what the Government, the public sector, can bring and to take maybe the best the private sector can bring.

One of the common values that are shared by the Enzi-Nelson legislation and the Lincoln-Durbin legislation is the notion that we have a lot of smaller employers, they have a lot of employees, and together is there some way we could pool their purchasing power? Maybe we could increase the number of health insurance options available to them and maybe we could bring down the cost of those options. They propose to do it in one particular way which, as Senator LINCOLN pointed out, has a number of problems, one of which affects us negatively in Delaware.

We have had a very high rate of cancer mortality. Finally, we have brought it down over the last 10 years or so, in part by having mandatory cancer screening—mammography, for cervical cancer, prostate screening, for colorectal cancers—and that has helped to bring down our cancer mortality rate. From the top in the country, we have finally now dropped to the top five. We are moving in the right direction. I will talk about that tomorrow, and I will even bring some charts to rival the chart of my colleague, I hope.

But I suggest to my colleagues, think about this. We have all these disparate Federal agencies across the country. Collectively, we have a couple of million employees, family members, and retirees, and all we do through the Federal health benefit plan is we pool our collective purchasing power. It doesn't matter if you work for the VA or Homeland Security or some other Federal agency—EPA—basically we could come together and use our collective might to negotiate better rates and, frankly, better coverage than would otherwise be the case if we were just negotiating for ourselves. We do it all through the Office of Personnel Management.

What Senator LINCOLN is suggesting is it works great for us, provides reasonably good coverage for Federal employees, including us as U.S. Senators. We have to pay our portion. It is not that we get it for free. We have to pay our share. But it works pretty darn well. She has come up with a way where we take that Government idea and transpose it and transfer it to the private sector. She would have the Office of Personnel Management effectively provide the service or play the role in the private sector that it currently plays in the public sector, to allow a lot of employees, whether you work for the local hardware store or restaurant or small manufacturer or technology company, to say: We would like our employees to be able to pull together from Arkansas, from Delaware, even from Minnesota, in order to get a chance to buy better insurance products, have more variety, and bring down our costs to our small business employees.

It has worked. It is proven. It is time tested, and I believe it is worth trying. The worst thing that I think could happen, coming out of this week, is for us to do nothing.

It is a big problem. It is a big problem for small employers, and it is a big problem for large employers. It is a big problem for America.

I think what would be the worst thing that could happen, and what would basically ensure that we do nothing is for our Republican friends to basically allow no amendments to the Enzi-Nelson legislation. I think that would be awful. That would be a huge mistake. It would pretty much basically ensure we end up not getting this bill done or some variation and not even having a chance for debate and vote on the Lincoln-Durbin legislation. We can do better than that.

Frankly, the Senate deserves a lot better than that.

I say to my colleague from Arkansas, who has been good enough to relinquish her time, I thank her on behalf of all us for pointing out a different course, a third way in this regard. I thank her.

Mrs. LINCOLN. Mr. President, I thank my colleague from Delaware.

The PRESIDING OFFICER. Minority time has expired.

Mrs. LINCOLN. Thank you, Mr. President.

I ask unanimous consent to continue until other Members arrive.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mrs. LINCOLN. Thank you, Mr. President.

I will be glad to yield the floor when others are ready to speak.

I would like to add that the experience of many of our colleagues, whether they are former insurance commissioners, former Governors and others, brings to this table the understanding what the American people want, what our working families want. I think the debate is that small businesses definitely want more affordable health care. They also want to make sure that what they are providing for themselves and their families and their employees is quality service, quality coverage. That is what they deserve. That is what they want.

Even for those who feel so young and invincible, we also know that they may be one car accident or one diagnosis away from needing more comprehensive health insurance for the rest of their lives.

That is why we want to make sure—as I said in the beginning—that whatever we do is right, that we don't move forward on something that is going to be less productive and in the long run, unfortunately, put more people at risk.

My goal is to help small businesses while not jeopardizing the quality of health care for the 68 million Americans in State-regulated group plans that are already out there. We don't want to do harm there.

The fact is if we move forward on what Senator ENZI wants to do, which is preempting those State regulations and State mandates, we could do tremendous harm for those who are currently insured and the 16.5 million Americans with individual health insurance coverage who would probably lose some quality of coverage which they have.

If it is good enough for Federal employees, and if it good enough for Members of Congress, I think it should be good enough for millions of small business employees who are the economic backbone of communities throughout this Nation.

I applaud my colleagues for coming to the floor for this debate, and I hope we will have a serious debate so we can

move forward and actually do what is right for the American people.

Mr. CARPER. Mr. President, will the Senator yield once again?

Mrs. LINCOLN. Yes, absolutely.

Mr. CARPER. Mr. President, we do not often think of the Federal Government in the way we are trying to harness market forces and competition and put them to work. We try to hold down Federal outlays. That is what we do with respect to the Federal. It is literally what we do with respect to the Federal Employee Health Benefit Plan. What we are trying to do, with respect to what the Senator has outlined, is harness market forces and competition and put them to work for small businesses as well.

Mr. ENZI. Mr. President, reclaiming our time, I didn't realize they would be allowed to use part of it.

It would be helpful if the other side would actually share the details of their amendment with us so that we can take a look at it. The details of our bill have been through the committee, out here, and had hearings. We don't know what is going to be in there. The last time I looked at it, there was, I think, $9 billion of cost in it each year, and the huge bureaucracy that would be built up. I make that request to the other side—that we sure would like to take a look at their bill. It is hard to do until we have a copy.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Mr. STEVENS. Mr. President, I thank the Chair.

CAPE WIND FACILITY IN NANTUCKET SOUND

Mr. President, I am here to discuss the provision in the Coast Guard and Maritime Transportation Act of 2006 and the provision which allows the State of Massachusetts to have a say in the siting of a 24-square-mile, 130-wind turbine energy facility.

I have a chart I want to use and describe.

First, let me say why the Senator from Alaska is involved in this issue. What I am trying to say is that this is a tremendous precedent.

We have a series of areas of various States where there is a gap in State jurisdiction and where Federal waters are adjacent to and sometimes almost surrounding State waters. That is particularly true in my State. With the Cook Inlet on either side of Kalgin Island, there are gaps of Federal waters surrounded by the mainland of Alaska going down the inlet.

The Minerals Management Service tells us there are roughly 2.5 million acres of Federal waters going down that inlet that could be used for projects such as I am going to discuss today.

A similar situation exists with Chandeleur Island, LA; the Channel Islands in California; the Farallon Islands in California; the Hawaiian Islands in many instances; and in Puerto Rico.

What I am here to talk about is the precedent that would be established by locating this facility in Nantucket Sound, less than 2 miles beyond the State of Massachusetts' jurisdiction.

If we look at this chart, you can see very clearly the area with the darkest color on the chart, which is the proposed site of this power facility. It is 9 miles from one part of Massachusetts, 13.8 miles from the other side, and 6 miles from the other direction.

When you look at the situation, we realize the State has jurisdiction over at least 3 miles in that area.

This is very close to the area of Massachusetts where people have a right to be concerned over this project. Before the Federal Government claimed ownership of this area, there was a judicial dispute over which government had jurisdiction over it. I am informed that the State of Massachusetts had established a marine park in this area. As a matter of fact, it was listed as part of a proposed marine sanctuary, even in the Federal listings. It is now the proposed site for the largest and most expansive offshore wind energy project ever undertaken in the world.

This facility would include turbines that stand 417 feet tall.

This is a chart that describes it. Those windmills would be 417 feet tall, taller than the Statue of Liberty. The one little point at the bottom shows a 30-foot sailboat. You can see the size of it. People sail their boats that size on Nantucket Bay, and the Great Point Lighthouse is supposed to keep sailors and mariners warned about the area. It is only 73 feet tall.

When you look this area, it is 24 miles across, more than half the size of Boston Harbor itself. It is going to be the site of this enormous facility.

As I said, it is larger than any similar kind of wind energy project in the world.

It is a very small area of Federal jurisdiction, completely surrounded by the mainland and islands of Massachusetts.

Some in the media have insinuated that by including this provision in the Coast Guard and Maritime Transportation Act, I am doing it as an old friend to Senator TED KENNEDY. He is an old friend. It is true that Senator KENNEDY and the Governor of Massachusetts support the provision in the Coast Guard bill, but this is my amendment. They have agreed with me. I didn't seek their agreement. It is not an issue based on friendship or on past favors or future favors. It is strictly a provision based upon my long-held belief that States should have the final say on projects which will directly impact their lands, resources, and constituents.

Some in the press have claimed this provision is embedded in ''obscure legislation to be passed in the dead of the night.'' We hear this all the time. But the Coast Guard authorization bill is hardly obscure legislation, and there is nothing secretive about this bill.

The version of this bill that passed the House of Representatives included a provision related to offshore wind farms. It was in the House-passed bill to start with. The House and the Senate, in a bicameral, bipartisan group of Members of a conference committee, discussed and negotiated language to provide the State of Massachusetts a greater voice in the siting of this windmill farm in Nantucket Sound.

This bicameral, bipartisan group also negotiated language requiring the Coast Guard to assess the potential navigational impacts of the proposed offshore powerplant.

This is the normal legislative process for passing legislation of this type through the Congress.

Again, let me point out this chart. I don't live in this area, but I have studied it very well. This is the path the ferries take coming out of these areas and going through this sound, and it is the path which the commercial traffic, steamships, and cargo ships use going into that port.

As a consequence of this location, this line demonstrates the State's jurisdiction and how close it is to the State's jurisdiction. As a matter of fact, the area that is has been lined shows the previous plan which would have gone partially into the State's jurisdiction. The project was amended, so it does not touch the State waters or State jurisdiction areas at all.

It is this area of solid brown on this chart.

By the way, this is the very shallow portion of this area. There is no question about it. Nantucket Island is out here. But there are equally shallow portions outside of the sound that could have been used. But, of course, it is deeper going in there, and that access to this interior part of this sound I think is strictly a financial decision.

At the heart of the debate on the issue is States' rights. The fact is this project will be located entirely in the sound—in this small doughnut hole of the Federal water surrounded by islands and mainland of the State of Massachusetts.

The debate over this project is similar to the fights those of us in Alaska have been engaged in for decades. Our State lands are surrounded by Federal lands, and we often don't have any decision regarding the development of our resources or projects which will be located in our State.

This is one of those situations where Congress ought to listen to the Governor. They ought to listen to the senior Senator, in my opinion.

Those in Massachusetts have raised legitimate concerns about the impact of this wind farm and what its impact will be on maritime navigation, aviation, and radar installations critical to our homeland security.

This proposed site is an area already known for its treacherous flight conditions, and this facility could make those conditions much worse. According to the National Air Traffic Controllers Association, this facility will be located in the flight path of thousands

of small planes. Both the Barnstable and Nantucket Airport Commissions are opposed to the construction of this facility, as are the major ferry lines that operate in Nantucket Sound.

As the chart I have described shows, ferry routes pass within a mile of the proposed location for this project on two sides. The 24-square-mile footprint for this facility is nearly half the size of Boston Harbor, a 471-foot wind farm.

Again, those windmills are larger than this building. Those windmills are larger than the Capitol.

You have to get the specter of this size being built in the center of this sound. It is a 24-square-mile footprint for this facility. As I have said, it is half the size of Boston Harbor and has shipping and ferry channels bordering on three sides.

There is not a single local fishing group from Massachusetts that supports this project, I am informed. It would effectively close a 24-mile-square-mile footprint of many kinds of fishing that has taken place in this sound for generations. Horseshoe Shoal, where the facility will be built, is one of the most productive fishing grounds in the area. That means this area produces offspring. This is where the fish spawn.

The impact of the shoal will be significant. The piling for each one of these windmills—there are 130 of them—are 16 feet in diameter and will be bored down into the shoal to a depth of about 80 feet. This productive area will be littered with 130 drilled holes. Each piling will occupy 2 acres of productive fishing ground. Navigating in and around 130 turbines will make fishing and fishing reproduction in this area nearly impossible.

In addition, these turbines will make Coast Guard search and rescue missions much more difficult in this area, already known for severe weather and sea conditions in parts of the year.

Those in Massachusetts raise another important point. Developing a wind farm of this size and scale offshore has never been done before, let alone in an environment as extreme as the waters of the North Atlantic.

To put this challenge in perspective, it helps to compare the Massachusetts project to the wind farm currently operating in Palm Springs, CA. I know a little bit about this. I have gone into that town several times by air. That facility stands 150 feet at the tallest point. The blades are half the length of a football field, but they are one-third of this size. Even on dry land and a relatively calm desert climate, the Palm Springs wind farm has been plagued by serious maintenance complications. Many of the turbines require constant maintenance and repair.

Put that in the Massachusetts Sound. They require maintenance and repair constantly. This Massachusetts project would require maintenance and repair to take place in icy waters of Nantucket Sound. The size of the windmills for this facility would dwarf the existing land-based wind projects. The windmills in Nantucket Sound would stand nearly three times as tall as those in Palm Springs, with wind blades over a football field in length. Just the blade is a football field in length.

Now, given the legitimate issues raised by the people of Massachusetts and their representative, I believe it is only fair to allow the State to have an equal voice in the debate over the siting of this project. Nantucket Sound, as I have said, is not the only place where a project of this kind can be built. In Europe, deepwater wind energy technologies are currently being developed as far out as 15 miles in 138 feet of water. Placing wind energy facilities further from their shore reduces their impact on maritime navigation.

If this 24-square-mile wind farm is built further away from shore, there would be a number of benefits. It would be removed from boating, fishing, ferrying, shipping channels, reducing the risk of collision and reducing the potential impact on the navigation which we have asked the Coast Guard to look into.

I do support America's use of alternative energy sources, including wind farms and wind power. I have supported wind projects in the past during my time as chairman of the Senate Committee on Appropriations. Our committee appropriated over $105 million for wind projects in fiscal year 2002 to fiscal year 2006. There was even one in my State around Kotzebue.

It is the right of a State to determine if this type of project is consistent with its efforts to protect its resources. I believe Congress should defer to the judgment of the Massachusetts congressional delegation, the Governor of Massachusetts, and the people of Massachusetts on this matter. States should have a say in the activities taking place in the waters adjacent to their shores. This location, in particular, deserves special consideration due to the geographic peculiarities of the region.

California blocked oil platforms, Oregon and Washington blocked them before they were even built.

We now have a dispute before the Congress over a potential development of gas resources 170 miles off the State of Florida. This is 3 miles. This is within a sound that is one of the—I have only been there two or three times, but it is a place if you ever go to it you would not forget. It is not a place that deserves to have this impact. The residents of Massachusetts will have to live with the impact of this project. They must have a greater role in determining the fate of this treasured area.

This bill, H.R. 889, as agreed to by the conference committee, rightly awards the State of Massachusetts this greater authority in the decisions regarding this project. So I am here today to urge the House and the Senate to listen to the people of Massachusetts and particularly to listen to their senior Senator.

I am pleased to yield whatever time I have remaining. I think I have only another 10 minutes or so. I yield to the Senator from Massachusetts.

I think we have 30 minutes on this side and 30 minutes on that side, is that correct?

The PRESIDING OFFICER. There is 14 minutes remaining on the majority side.

Mr. STEVENS. Is there time on the Democratic side for the Senator from Massachusetts?

Mr. KENNEDY. We are rotating back and forth. I am happy to work that out.

Mr. STEVENS. We will work that out.

Mr. KENNEDY. We will stay on the subject matter.

Mr. ENZI. We had some latitude here to allow 20 minutes on this and we were 5 minutes late from that one.

Mr. STEVENS. I talked too long.

Mr. ENZI. And Senator THUNE does not have the time for his speech.

Mr. THUNE. Mr. President, I cannot yield, but if the Senator from Massachusetts requests time and wants to use the Democratic time for that, we have 14 minutes on the majority side I would like to use to talk about the small business health plan. But if the Senator from Massachusetts wants to use Democratic time, that is fine.

Mr. KENNEDY. I ask to be yielded 8 minutes on the Democratic time.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I thank my friend and colleague, the Senator from Alaska.

I hope to have an opportunity to get into this in greater detail than I will for the few minutes I have this afternoon.

There are certain points I want to make. That is, the waters around the area described by the Senator from Alaska, the Nantucket-Martha's Vineyard-Cape Cod area, has been designated a state ocean sanctuary and it is an unreplaceable asset to the people of Massachusetts. Up to 1986, it was generally recognized to be under the jurisdiction of the Commonwealth. In the 1970s, Massachusetts was concerned about potential development threats and made the entire area a protected state ocean sanctuary—where no structures could be built on the seabed and where no offshore electricity generation facilities could be constructed.

The legislation was passed easily through the State House. And the specific part of Nantucket Sound that is no longer protected by the state laws, because of a Supreme Court decision, is under consideration for national marine sanctuary status.

My second point, Mr. President, is that I am for wind energy. We all know we need it to meet our future needs, and we've seen the successes that onshore wind energy farms can be. We ought to have offshore wind energy, but we need to get it right.

The problem in Massachusetts is that we have a developer who's basically staked a claim to 24 square miles of Nantucket Sound back when there were no rules on offshore wind development, and then got the project written into the new law so the new rules won't apply to this project.

And the practical effect is that there will be no competition for the developer and that his application is being reviewed and processed before the Department of the Interior can even complete a national policy.

In the Energy bill, section 388 says:

. . . the Secretary shall issue a lease, easement or right-of-way under paragraph (1) on a competitive basis unless the Secretary after public notice of a proposed lease, easement or right-of-way that there is no competitive interest.

The next provision says:

Nothing in the amendment made by subsection (a) requires the resubmittal of any document that was previously submitted or the reauthorization of any action that was previously authorized with respect to a project for which, before the date of enactment of this Act—

(1) an offshore test facility has been constructed;

Well, where in the country was there a project that had an offshore test facility?—only in Nantucket Sound. So this was a real special interest provision.

Because of this ''savings provision,'' the developers are pushing Interior to complete this review before the rules of the game are even established and before the ocean is zoned.

So while Interior is setting a uniform program—and deciding which sites should be used—this project is on the fast track. The developer and the developer alone picked the site.

And this is a serious problem. Look at what the EPA said about this project's draft environmental impact statement. They called it ''inadequate.'' That's from the EPA, the agency charged with protecting the environment.

And the EPA wasn't alone. Look at what the US Geological Survey said about Cape Wind's draft environmental impact statement:

. . . the DEIS is at best incomplete, and too often inaccurate and misleading.

Inadequate—Incomplete—and too often inaccurate and/or misleading. Does this sound like project that should be on the fast track?

But because they've been written into the law, the interests of our state have been basically submerged to a special interest developer.

They complain about the provision in this bill that Senator STEVENS negotiated with the House. He's right. He's trying to at least bring this back up for review under the sunlight and ensure that the interests of the state for safety and for environmental protection aren't run roughshod over.

The project's developer is the one that got the special interest legislation. This Coast Guard provision is designed to check that and preserve the public interest.

The provision Senator STEVENS crafted tries to remedy an injustice the developer created, and at least let the people of our State be heard.

We wish this provision wasn't necessary, and it wouldn't be if the developer was content with following the rules that apply to everyone else.

That would have been satisfactory, but no, we are denied that equal treatment. We are prohibited from that. That is not right.

Our State went out and created the Cape and Islands Ocean Sanctuary as a protected area. Then the Supreme Court cut a hole in those protections, and now the interests of the State to preserve the fisheries and environment of the whole region is being undermined. It is being handed off to private interests. It's not right. We deserve to have at least a little fairness in this.

I will not take the time to list the various national marine sanctuaries, including the Channel Islands, all the Florida Keys, and other national treasures, like Stellwagen Bank outside of Boston, which I am so happy we have protected into the future.

The law says you can't build energy facilities in those sanctuaries and we shouldn't—and Nantucket Sound is just as important as those.

For 400 years the Sound was considered Massachusetts waters, and it was a protected by the people of our state.

In preparation for the 1986 Supreme Court decision that would specify that this narrow area would be carved out as Federal land, we took special care to get on the national marine sanctuary site evaluation list. We didn't want to take any chances then, and we're still on the list. At a minimum, no industrial project should be built there until we can resolve that status.

And now we have a developer who wants complete control over 24 miles in the middle of the Sound, even though no government agency has zoned it for energy development yet.

We know that the U.S. Commission on Ocean Policy called for a comprehensive siting policy, and that Interior is now working on it. We endorse that approach completely, but this developer is undermining that.

And the American people should know just what this developer is getting for this no-bid, no-compete contract. There will be at least $28 million a year in federal tax benefits available to the developer that's $280 million over 10 years.

And in Massachusetts, the developer will be eligible for between $37 million and $82 million a year in price subsidies under the renewable energy credit program. That's $370 million to $820 million in price subsidies over 10 years.

Then there's the fact that the company will be able to write off the $800 million cost of this project off in just 5 years.

This is a boondoggle, and it's an outrage the developer's getting a no-bid contract to a public resource. We've seen what no-bid contracts can do, Mr. President.

Who pays when we talk about subsidies? It comes out of the taxpayers' pockets when we talk about subsidies.

It is a great deal for this developer. It is a great deal for his investors. It is a great deal for the venture capitalists. They will get so much money they will not be able to count it. But it shouldn't be done without the voice, without the consideration, and without the interest of the State, let alone the many groups that oppose this project and fear that it will undermine the safety, environment, and economic interests of the region for years to come.

I thank the Senator from Alaska for his hard work on this bill and this provision.

Let me ask the Senator—and I know the time is up—I understand if this proposal were for an LNG facility in Nantucket Sound, the Governor of Massachusetts would have the same authority under the Deepwater Port Act that we're seeking here for this project. Am I correct?

Mr. STEVENS. That is right.

Mr. KENNEDY. We need LNG and we need more energy sources, but if they had decided here to do an LNG on this site, the Governor would have a voice in that, am I correct?

Mr. STEVENS. I believe the Senator is correct.

Mr. KENNEDY. So this idea about having a voice on this makes a good deal of sense.

I thank the Senator from Alaska.

I yield the floor.

The PRESIDING OFFICER (Mr. MARTINEZ). The Senator from South Dakota.

Mr. THUNE. Mr. President, how much time is remaining on this side?

The PRESIDING OFFICER. Ten minutes remains.

Mr. THUNE. Mr. President, I ask unanimous consent, if necessary, that I have a couple of additional minutes beyond that. I believe the other side was granted a little bit of extra time when they were addressing this issue as well.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered. The Senator will have an additional 2 minutes.

Mr. THUNE. Mr. President, last week the Robert Wood Johnson Foundation sponsored ''Cover the Uninsured'' week, a call for this country to wake up and address a huge and growing problem in our Nation. In 2004, approximately 19.1 percent of nonelderly Americans did not have health insurance. That number is growing.

Why do we have this problem in one of the wealthiest nations in the world? It is because nearly one-half of the 45 million uninsured individuals in the United States are either employees of small firms or family members of small business employees.

The primary reason cited by small businesses themselves for not offering health benefits is simply the high cost of health insurance. We can do something about that beginning today. We

also have this problem because Congress has repeatedly failed to do its job in the past. We can also do something about that, beginning today.

Today the Senate voted on a motion to proceed to S. 1955, which is a bipartisan bill addressing the issue of the working uninsured. This legislation allows the creation of small business health plans to help lower the cost of health care for small business owners and their employees.

Our colleagues on the other side have also offered some legislation today to address this issue. Senators DURBIN and LINCOLN have talked about their particular proposal, which is a Government approach. In fact, they say it saves money, but it shifts the costs over to the taxpayers, to the tune of $73 billion over a 10-year period. Why would we ask for taxpayers to foot the bill before we have allowed the small businesses of this country to take advantage of a market-based approach and to use the market forces that exist out there in a way that would drive health care costs down for them and their employees? It is very simply a difference of philosophy.

Our philosophy—the approach contemplated under S. 1955—deals with a market-based solution to this issue. The proposal, S. 2510, by our colleagues on the other side is a Federal Government solution to this issue, at a great cost, I might add, to the taxpayers of $73 billion over a 10-year period.

S. 1955, the Enzi bill, which, as I said earlier, we were able to move to proceed to today, would lower the cost of care for employers and employees. In addition, the Congressional Budget Office estimates S. 1955 would reduce net Federal spending for Medicaid by about $790 million over the next 10 years. It would also save the States of this country about $600 million in the cost of Medicaid over a 10-year period. That is in addition, as I said, to the savings that would be achieved for small businesses.

The Congressional Budget Office has analyzed this particular piece of legislation and concluded it would save somewhere between 2 and 3 percent for small firms in this country on the cost of their health insurance. What is significant about this, as well, in contrast to the proposal by our colleagues on the other side, which would cost an additional $73 billion over the course of the next 10 years, is the Congressional Budget Office said that the Enzi bill, S. 1955, would increase tax revenues coming into the Government by $3.3 billion over 10 years because lower spending on health insurance would increase the share of employee compensation paid in taxable wages and salaries versus tax-excluded health benefits. In other words, lower spending on health insurance would translate into higher wages and salaries and actually would also generate more revenue for the Federal Government rather than less, which is what would happen under the proposal by the Democrats, which would cost the taxpayers $73 billion, according to the Congressional Budget Office, over a 10-year period.

So I believe it is important we move forward and we vote to send S. 1955 out of the Senate to conference with the House. As a Member of the House of Representatives, I voted for the creation of small business health plans numerous times. In fact, that particular proposal has been voted on no fewer than eight times in the House of Representatives.

Every time I voted when I was a Member of the House, and every time it has been passed by the House of Representatives, it has come to the Senate and has been unable to be voted on because it has been filibustered, obstructed by the other side. I would say, that is in spite of the fact that if it were allowed an up-or-down vote in the Senate, I believe there would be a decisive bipartisan majority in favor of this legislation.

Unfortunately, due to obstructionism, the Senate, until today, has never voted on legislation creating small business health plans. As a Congressman and now Senator, I have listened to many accusations about the harm that S. 1955 or similar legislation would do if it were enacted.

What harm would be caused by decreasing the cost of health care for small employers by 12 percent and increasing the coverage of the working uninsured by 8 percent? Lower cost and more coverage for those who are currently uninsured: That is not harm. That is exactly what we ought to be accomplishing here by enacting legislation that would make health care coverage more affordable and more available to more Americans.

South Dakota has an estimated 72,949 small businesses as of 2004, which is an increase of 2.4 percent from the previous year in 2003. South Dakota also had an estimated 90,000 uninsured individuals or 12 percent of our population in the year 2004. Fifty-two percent of South Dakotans had employer-based health insurance, 8 percent below the national average.

Small businesses are the backbone of South Dakota's, as well as our Nation's, economy. It is time these businesses were placed on a level playing field and allowed to pool together to purchase health insurance, like large employers and unions.

I have heard from many provider groups in my State of South Dakota concerned about coverage for their specific services. S. 1955 allows small business health plans to offer a basic benefit plan that would be exempt from State mandates as long as the small business health plan also offers an enhanced benefits option that includes at least those covered benefits and providers that are covered by a State employee health benefit plan in one of the five most populated States in this country.

According to the Council for Affordable Health Insurance, all of these States—all of these States—require coverage for alcoholism, breast reconstruction, diabetes self-management, diabetic supplies, emergency services, mammograms, mastectomy stays, maternity stays, general mental health, chiropractors, optometrists, podiatrists, psychologists, and social workers.

Small business owners want to give their employees the best health coverage possible under their budgets to recruit and retrain their workforce. Facts suggest self-insured large company health plans, currently exempt from State mandates, generally cover services important to their employees.

This legislation would create new options for small businesses and the potential for a choice in health plans for their employees. Today, only 10 percent of firms with 50 or fewer employees offer their workforce a choice of more than one health plan. Lowering the administrative costs of health insurance plans will give small firms new and better coverage choices for their workers.

Additionally, the GAO found that the added cost of mandates to a typical plan is between 5 and 22 percent. CBO estimates that every 1-percent increase in insurance costs results in 200,000 to 300,000 more uninsured Americans. When the cost of health insurance goes up, coverage and access go down.

The concept behind S. 1955 is very simple: to provide health insurance to small businesses that is both affordable and accessible. Small businesses not only in my State of South Dakota but across the Nation have been fighting for the creation of small business health plans for over 10 years. It is high time that the obstruction end in the Senate, that the Senate step aside and allow an up-and-down vote on this very important legislation.

As I said before, it is legislation that, if you look at just the Congressional Budget Office findings, would cover nearly a million more people, would allow three out of every four small business employees to pay lower premiums than they currently pay under current law, and would see small firms' premium costs decline by 2 to 3 percent. The average decrease per firm would likely be greater, since the CBO estimate is a total that factors in the costs of other benefits added by firms in response to the reduction in premiums.

It would also allow annual spending on employer-sponsored health insurance to be reduced by about $2 billion in a 5-year period. As I said earlier, it would increase Federal tax revenues by $3.3 billion over 10 years because lower spending on health insurance would increase the share of employee compensation paid in taxable wages and salaries versus tax-excluded health benefits—more coverage; lower costs; more revenue to the Federal Treasury, not less. The alternative offered by our colleagues on the other side, as I said earlier, comes at a high cost to the taxpayers: $73 billion over a 5-year period.

We can do better. We can allow the market forces of this country to be used. We can take a market-based approach to this issue and do something that has been done a long time ago, something that has, as I said, been voted on repeatedly in the House of Representatives, never to have been voted on here in the Senate, because it has been blocked.

It is high time for the small businesses of this country, for their employees, for families who lack coverage today, to have another tool at their disposal, a tool that takes into account and takes full advantage of market forces, by allowing small businesses to group together to leverage their size, to drive down the rates they pay for health insurance and, thereby, cover more of their employees.

That, again, is in stark contrast to the model and the proposal that is being offered by our colleagues on the other side, which consists of a government-based solution, that comes at a very high cost to the taxpayers, that calls for more bureaucracy and redtape, and does nothing in the end to bring down the cost of health care for small businesses in this country.

It is long overdue. I hope, as we have the chance to debate this now in the Senate, once that debate is concluded, we will be able to proceed to a vote because the one thing that has always been missed here in the Senate, despite action on eight different occasions in the House, is an actual up-and-down vote in the Senate that would allow the Senate to speak on the issue of whether we want to do something meaningful to reduce the cost of health care for small businesses in this country, to provide more coverage for those who are currently uninsured, and also to do something that would reduce the cost to the Government, the cost of Medicaid, as well as the other costs that are associated, as I said earlier, by increasing the amount that would come into the Treasury.

For those reasons, Mr. President, I ask my colleagues to support this legislation.

I yield back the remainder of my time.

The PRESIDING OFFICER. The time until 4:30 is controlled by the minority.

The Senator from Iowa.

Mr. HARKIN. Mr. President, here we are on day 2 of Health Week, and there are still no plans to bring up H.R. 810, the stem cell research bill.

This bill was passed by the House of Representatives 351 days ago—almost a year ago now—with still no action here in the Senate. Yet the majority of Senators are for it. I do not understand how in the world we can have a Health Week in the Senate and not vote on the American public's No. 1 health research priority: lifting the President's restriction on embryonic stem cell research.

That seems to be what we are doing. We are wasting our time on bills that everyone knows are not going to pass. We are passing up a golden opportunity to promote one of the most promising areas of research in our lifetimes.

Most people by now have heard of the enormous potential of embryonic stem cells. These cells have the remarkable ability to turn into every other type of cell in the human body—brain cells that could replace those lost in Parkinson's disease, islet cells to replace those lost in type 1 diabetes, and on and on. Adult stem cells don't have that power, only embryonic stem cells. That is why the world's best scientists think embryonic stem cell research has so much promise to save lives and ease human suffering. It is also why they are so frustrated by the President's arbitrary restrictions on stem cell research.

Under the President's guidelines, Federal funding can be used for research only on those stem cell lines that were created before August 9, 2001, at 9 p.m. Where did that date come from? Out of thin air? If the stem cell lines were created at 8:30 p.m., they are fine, they are moral, they are OK. If they were created at 9:30 p.m., all of a sudden they missed the cutoff. It is totally arbitrary.

Shortly after the President announced his policy, he said 78 stem cell lines were eligible under his guidelines. It turns out that only 22 are. In fact, it is even worse. Only a handful of those are even healthy enough and readily available. More importantly, all of the 22 lines that are available have been contaminated by mouse cells. They have been grown in a mouse feeder cell environment. It is unlikely they will ever be used for any kind of human intervention, which is supposed to be the whole point of the research anyway.

Dozens more stem cell lines have been created since August 9, 2001. They are healthier. Many have never been contaminated with mouse cells. But thanks to President Bush, they are off limits to our best scientists.

Yet opponents of H.R. 810 sometimes argue that embryonic stem cell research has no potential. Last week, Senator BROWNBACK presented a list of diseases that are being treated with adult stem cells and asked why that hasn't happened yet with embryonic stem cells. Let me address that directly. Scientists have been doing research on adult stem cells for over 30 years. There are no arbitrary restrictions on research with adult stem cells. Scientists and private companies don't have to be skittish about doing this research. They don't have to worry that all of a sudden the Federal Government is going to ban it or limit it.

Let's compare that situation with human embryonic stem cells. Scientists didn't even know how to derive them until 1998. The first Federal grant for these stem cells wasn't awarded until 2002. Even now, only a tiny fraction of the total Federal budget for stem cell research is used for embryonic stem cells. The vast majority goes for adult stem cell research, and every scientist who enters this field is taking a risk that Congress will pass a law to shut down the lab. They also risk that they won't get any 1 of the 22 lines contaminated by mouse feeder cells which they will then not be able to use for human therapy. So it is no wonder that more diseases are being treated today with adult stem cells. Adult stem cell research had a 30-year head start. Meanwhile, scientists have been studying embryonic stem cells for just 5 years with one arm tied behind their back.

The fact is, it doesn't matter what I think about the potential of embryonic stem cell research. It doesn't matter what Senator BROWNBACK thinks either. What matters is what the scientists think. And I defy anyone to find a single reputable biomedical scientist whose doesn't believe we should pursue embryonic stem cell research.

I have a letter from Dr. J. Michael Bishop who won the Nobel Prize in medicine in 1989. He writes:

> The vast majority of the biomedical research community believes that human embryonic stem cells are likely to be the source of key discoveries related to many debilitating diseases. . . . In fact, some of the strongest advocates for human embryonic stem cell research are those scientists who have devoted their careers to the study of adult stem cells.

A letter from Dr. Alfred G. Gilman, who won the Nobel Prize for medicine in 1994:

> It has become obvious, however, that the number of stem cell lines actually available under current policy is too small and is controlled by a limited monopoly, which has made it significantly more difficult and expensive for research to be conducted. These limits have hindered the important search for new understanding and treatment of devastating diseases.

I have similar letters from Dr. Ferid Murad, who won the Nobel Prize for medicine in 1998; Dr. Arthur Kornberg, who won the Nobel Prize in medicine in 1959; and dozens more of our Nation's top researchers—all of whom believe in the potential of embryonic stem cell research. I ask my friend from Kansas, in response to his speech of late last week: Are there any Nobel Prize winners in medicine who oppose embryonic stem cell research? Name one.

In fact, I challenge him further: Are there any reputable biomedical researchers at all who think we should be studying adult stem cells only and not embryonic stem cells? Name one.

I don't think he will find one. Every scientist I have spoken to says stem cell research should not be an either/or endeavor. We should not be talking about stem cell research or embryonic stem cell research. We should study both. We should open all doors in the pursuit of therapies that can save lives and ease human suffering. The breakthroughs are coming, but they take time. To clamp down on embryonic stem cell research before it even has a chance to start shows a total lack of understanding about how science

works. More importantly, it denies hope to millions of Americans who suffer from Parkinson's, ALS, juvenile diabetes, spinal cord injuries, and dozens of other terrible diseases and conditions.

We are rapidly approaching the 1-year anniversary of the vote in the House on H.R. 810. It has been 351 days since the House passed it on a strong bipartisan vote. If the Senate were allowed to vote on H.R. 810, we would win here, too. We have the votes. We would pass this bill and send it on to the President. Regrettably, however, the Republican leadership has not let that happen. So here we are, we are going through this farce—it is farcical—comedy, gimmickry of a so-called Health Week without taking up the American public's No. 1 health research priority.

It is Tuesday. Health Week lasts for 3 more days. We could pass H.R. 810 in a matter of hours. I urge the majority leader, take up the bill. Let the Senate have a quantified amount of time to debate it. We will pass it, and we will give millions of Americans who are suffering from diseases the hope they deserve.

I yield the floor.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, before he leaves the floor, I say to my colleague from Iowa, Senator HARKIN, how much I appreciate his leadership in the area of health care. His analysis of where we stand on the stem cell issue is so appropriate, and he is so right. Here we have a whole area of scientific research that is waiting to take off. We have States, such as mine and others, that are taking the lead instead of following the lead of the Federal Government.

I say to my friend, does he ever remember a time in history when this country was plagued by disease that the Federal Government didn't step to the plate, whether there was a Republican President or a Democratic President? Isn't it shocking that as we face these epidemics of Alzheimer's and Parkinson's and cancer and heart disease and all the others my friend mentioned, isn't it amazing—I am sure it is to him as well as to me—that we have a lack of leadership in Washington?

Mr. HARKIN. I say to the Senator from California, it is not just amazing, it is shameful. It is shameful what is happening now with the lack of support for biomedical research, especially embryonic stem cell research. As I said, every Nobel Prize winner in medicine, all the reputable scientists say we should be on it and we should be on it strongly. Yet the President, through this arbitrary cutoff, is denying this for scientists, denying it to people who are suffering. I say to my friend from California, God bless California. They took the lead out there. Her State has taken the lead. They are forging ahead. Other States are following their lead. If only we could get the Federal Government to follow their lead.

Mrs. BOXER. As my friend pointed out in his statement, we have the votes for stem cell research, even with the President's opposition. If we asked for a show of hands in any roomful of people: Have you been touched by cancer, have you not personally or someone you know been touched by heart disease, by stroke, by Alzheimer's, Parkinson's, paralysis, all these things, we know how many hands would go up.

Mr. HARKIN. Juvenile diabetes.

Mrs. BOXER. That is clearly one. And I have met with juvenile diabetics. I have met with the children, the parents and the families. They are counting on us. Here we are in Health Week, as my friend points out. We have the votes. Yet what do they bring up? A bill that is actually going to take away health care from people, the Enzi bill.

Mr. HARKIN. Exactly. I appreciate my colleague from California. She is right on target. I know my friend from California, the distinguished Senator, has been in the forefront of fighting for the things that will help people have better lives, especially in health care, and to ease the pain and suffering of people, especially juvenile diabetics.

As the Senator knows, the families tell us that perhaps one of the first therapies that could come from embryonic stem cell research would be for these kids suffering from juvenile diabetes. What a great day that would be.

I thank the Senator for her comments and strong leadership in all the areas of health care, and I thank California, through her, for the leadership they have shown.

Mrs. BOXER. I am very proud of my State.

In my State the gentleman who took the lead in putting the stem cell research initiative on the ballot has a child with juvenile diabetes. Watching that child suffer and struggle motivated him. He ignited this wonderful movement in our State. Shockingly, here we are in Health Week and this thing is nowhere to be seen. It is another example of why we need change around this place. I thank my friend.

This Health Week Republican style is really fascinating when you look at the bills that have come before us. The first two bills would have hurt patients who were injured by malpractice, patients who might have been made infertile or harmed in many ways. Those two bills took away the rights of patients.

The PRESIDING OFFICER. The minority's time has expired.

Mrs. BOXER. I ask unanimous consent to speak another 15 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. ENZI. I object.

The PRESIDING OFFICER. Objection is heard.

Mrs. BOXER. I ask unanimous consent to suggest a quorum call.

Mr. ENZI. Mr. President, under the unanimous consent agreement, we are alternating every 30 minutes.

The PRESIDING OFFICER. Under the precedents of the Senate, the Senator must control at least 10 minutes in order to suggest the absence of a quorum.

Mrs. BOXER. I ask unanimous consent that at 5 o'clock I be given the floor for 10 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. ENZI. Mr. President, reserving the right to object, the Senator's side controls the time at that time. So if they want to give the Senator the 10 minutes, there would be no objection to that. It would come out of the Democratic time.

Mrs. BOXER. I thank the Chair.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Wyoming.

Mr. ENZI. Mr. President, first, I apologize for the confusion over the unanimous consent that we had. It was designed early this morning to make sure each side had an opportunity to have an equal amount of say on the 30 hours that we are working on in order to actually get to amendments on this bill. Now that we have had cloture and everybody has agreed, or almost everybody, that we needed to proceed on the bill, we are talking about an issue that is huge to small businesses out there and wanting to find some kind of solution. We even suggested that perhaps they would like to reduce the number of hours of debate about the right to proceed so that we could actually get to offering amendments. But we have a 30-hour time requirement. That could be reduced by unanimous consent, or even eliminated by unanimous consent. But it has not been, so we will try to keep on a half-hour rotating basis so that as many people as possible can have something to say on the bill.

I am going to take a few minutes at this point to talk about this issue. We have been talking about health care. One advantage of having this 30 hours is to have some additional health care debate. I need to talk a little bit about prescription drugs Part D. That is not part of the motion to proceed, but it has been talked about a number of times on the Senate floor today. There are some confusing things out there for seniors that I would like to clear up.

I have been taking the last two recesses to travel across Wyoming and hold meetings with senior citizens to explain the prescription drug plan to get them signed up so they can get the benefit. There is some confusion out there. When we were designing the plan, we were worried that there would not be any plan interested in our small population in Wyoming. We have less than 500,000 people in our State. Our biggest city has 52,000 people. So we have a little bit of trouble finding a big enough pool for anything and to encourage interest. So I asked that there be kind of a Federal backup plan on it, and that was put in the bill.

But when the time came around for companies to offer plans in Wyoming, obviously, they were even excited about 500,000 people because we had 41

plans respond. That is competition. That competition brought the prices down by 25 percent before the people even applied for the benefit. A huge decrease in cost; that is cost by competition. The downside is that 41 plans create confusion. If you have ever tried to buy insurance and talk to a number of different insurance salesmen, every package is designed slightly different to make it a little bit more confusing so that their plan looks better, but it is also harder for you to make comparisons.

There is an easy way to make comparisons. Medicare saw that coming and set up a computer analyzation so that all you have to know is what your prescriptions are and what the doses are. You can put them in over the Internet or you can talk to somebody live by an 800 number or there are a lot of volunteers across America who are helping to get this information out. It lets Medicare do the math. They will present you with three or four plans that meet your prescription, your doses, and your criteria for where you want to buy it. You can look at these line by line. All the lines match up and you can compare them and find the best one for you. It has been a tremendous help.

My mother asked me to help her on her decision. There are kids across the United States—kids like me—who need to be helping their moms on these kinds of decisions. I was happy to do it because it gave me an opportunity to try out the telephone method, the Internet method, and I talked to a number of volunteers and the local pharmacist. We owe the local pharmacist a great deal of thanks for the way this is working and the difficulties that they have had doing a new program. We have not had a big change in the program in decades. When we first had Medicare, there were problems. They got worked out. When we started this one, there were problems, and I think they have mostly been worked out.

Occasionally, at these hearings, somebody was having a problem. A hour and a half was the longest it took us to straighten out any problem for anybody. I ran this process and came up with these four best at the least cost for my mom.

One of the things that people raise in those sections is they say: I don't need any drugs so I should not have to do this. I should not have to pay a penalty later.

The way insurance works is that you buy into the plan usually before you get sick. You pay a premium and when you get sick, then you have the coverage for the things that can happen to you in the future.

Medicare prescription Part D is completely different because you can already have a huge medical problem and a lot of prescriptions and you can sign up for this now and have a maximum guaranteed cost. I know of people who are actually saving thousands of dollars because they signed up. If you don't have anything the matter with you and you don't want to buy into a big plan, you run the evaluation and you can find a small plan you can buy into.

One in Wyoming is $1.87 a month. What if the $1.87 a month doesn't cover me if I have something really bad happen to me? Well, every November 15 to December 31 you can change your mind. You can change your company, and they cannot stop you. Tell me where else insurance works like that. Every November 15 to December 31, you can change your mind and sign up for a plan that has new kinds of benefits for you that match new illnesses that you might have.

This is working for the people who have paid attention. It is easy to have Medicare do the math. So everybody out there who hasn't signed up needs to talk to the volunteers, probably at their senior citizen center or call the 1–800 number or get on the Medicare Internet site and have that plan figured out for you. It takes a few minutes and you can be set so that you, first of all, won't have any penalties, but, secondly, you will have some tremendous benefits as you need the medication. It has made a huge difference.

Some people have talked about negotiating the price. When I was doing these hearings, I had some difficulty with people who showed up and said: You know, there are some medications I really want to have, that I am supposed to have, and I cannot get them. Well, when I checked, those were the veterans, and the veterans' prices are negotiated, and when they negotiate prices, they pick a similar drug and get the best price by kind of fixing the price on it and driving the price down through this bidding war. But it eliminates medications. Yes, there are medications you can take. It may not be the medication your doctor thinks is absolutely the best. But that is what happens with negotiated prices.

So what we relied on in the Medicare prescription Part D was competition, and competition has happened. Prices came down 25 percent, and then people who signed up for the program who are using medications found out that they are also saving another 25 percent as the least amount, or 37 percent as the average amount, and some people are getting 83 percent—I say some people. I know some people who are getting several thousand times more than what they are paying in because they are into the catastrophic care. I wasn't even listing the catastrophic care.

The important thing is that we need to tell people and help people to sign up by May 15. It is a tremendous benefit. We have had more people sign up than we had anticipated signing up. That means, again, a bigger market; that means lower costs. So it works for all of us when people sign up. Remember, there are plans out there. If they have them for $1.87 a month in Wyoming, I bet they have that at $1.87 or less every place in the country. Look at those if you are not using any medication.

So that is what competition does. That is the purpose of the bill that we are talking about and that we have actually had the motion to proceed on, not the ones that fall under other committees' jurisdictions, such as Medicare or stem cells or some of the other things that have been talked about here. Those are things that actually—this falls under the jurisdiction of the Health, Education, Labor and Pensions Committee. We took the bill through committee that has never been through the Senate before. The House passed a bill that is considerably more liberal and difficult than the one that we passed. They passed it eight times over there in a very bipartisan way. If we have the same Democratic Senators over here vote for it that had Democrats in the House vote for it, we will pass this bill easily. Even if there is a filibuster, we will pass it because it is a concept that small businesses have been asking for. This is the first opportunity we have had to provide it for them.

We did it by being very conservative in the approach and going to a situation where we could work across State borders, so that associations could build a big enough pool that they could effectively work with their insurance companies to get these multiple competition bids. We are certain that it will work. One of the reasons we are certain that it will work is because it has been tried within States. But those who have tried it within States have found that it works very well, and they know it would work even better if they could go across State borders. So even those who are doing it are asking to do it on a wider scale than what they have been. For a lot of the States that have less population, yes, they want to be able to do it at all. They don't have big enough pools within their States to do it, so they want to be able to go across the State borders.

I want to discuss a little bit why we need to pass S. 1955 and allow for the creation of these small business health plans. First of all, the concept of allowing small businesses to join together to find better prices for health insurance is not new, as I mentioned. Many organizations have offered nationwide health plans to members in the past. But States continued to add mandated benefits and other regulations to their insurance markets during the 1980s and 1990s, and the administrative hassles and costs associated with the mandates and regulations became too much of a burden for existing plans that could no longer offer an affordable benefit on a national basis. So they discontinued the plans.

The Associated Builders and Contractors organization, known as ABC, is an unfortunate example of this problem. Their insurance carrier refused to continue doing business with the ABC insurance trust in the late 1990s because

the panoply of 50 different State regulations and excessive benefit mandates made it impractical and unattractive for the insurance company to continue the program. ABC was unable to find another carrier to pick up their business.

This chart kind of shows how health care costs have gone. I don't think there is any argument on either side of the aisle that this is what has happened. There has been a rapid escalation, and compared to what it used to be, there has been a rapid escalation for a long time, oddly enough. We are up to a national average cost per employee of about $8,000 a year. That doesn't include the part the individuals are paying, which brings it up to about $11,000 a year. That is the amount we have been talking about on both sides of the aisle today.

What is truly unfortunate is that workers at ABC's member companies were benefiting from this program, and the companies were saving money on their health care expenses. The health plan sponsored by ABC for nearly 45 years had total administrative expenses of about 13 cents for every dollar in premium. These costs included all marketing administration, insurance company risk, claim payment expenses, and State premium taxes. Compare this to the small business employers who purchase coverage directly from an insurance company. The total expenses for most small businesses today can approach 35 cents for every dollar of premium. So saving nearly 25 cents on a dollar is real money, especially in today's health insurance prices.

The other benefit to ABC's member companies and employees is that any profit generated by their health plan stays in the plan. This also helped keep costs down. So the idea isn't new, and it has worked before.

But Congress needs to act before small business organizations can resurrect their defunct programs and before other organizations can start new ones. Congress considered fixing this problem during debate over the Health Insurance Portability and Accountability Act in 1996—it is better known as HIPAA—but the small business affordability provisions in the House bill were dropped during the conference between the House and the Senate in the final bill. As a result, HIPAA only addressed access to health insurance and not affordability. So now everyone has access to health insurance policies, but the policies themselves are unaffordable to many. When I became chairman of the Committee on Health, Education, Labor, and Pensions last year, I announced that I would bring a health insurance affordability bill before the committee so we could finish the job we started 10 years ago—in other words, to make it possible for all Americans to have access to a health insurance policy that is affordable.

Many were skeptical then, and some may still be skeptical now, but the time for more of the same is over. America's working families want change, and they are tired of excuses from Congress.

Small businesses and working families are demanding relief from high health insurance costs. And it is no wonder. This year, employers are paying twice what they were paying in the year 2000 for health insurance. That is correct. What businesses paid for health insurance has doubled over the past 6 years. That is a pace we can't keep up.

This cost squeeze hurts small businesses the most. The highest rates of uninsured workers can be found in businesses with 25 or fewer workers. Only 60 percent of the Nation's businesses are offering health insurance these days, down from nearly 75 percent just 5 years ago.

Small businesses and working families are stuck on the escalator of rising health insurance costs, with no end in sight. And in a tight labor market, small business owners don't want to jump off this fast-moving escalator because dropping health insurance puts them at a major disadvantage in competing for the best workers. We need to give them a safe place to get off this escalator of rising costs, somewhere where it is more affordable for themselves and working families, and the small business health plan will give them that option.

Mr. President, I yield the floor to the Senator from North Carolina.

The PRESIDING OFFICER. The Senator from North Carolina is recognized.

Mr. BURR. Mr. President, the chairman has brought a carefully crafted piece of legislation to the Senate floor, one that took a tremendous amount of skill to negotiate and one that has incredible support—more support when the bill passed out of committee than it does today. Why? Because people now fear it might become law. People fear this might pass, and they never believed it would. What does it do? It brings additional competition to the marketplace, but more importantly, it brings health care coverage to Americans who have no coverage today.

Why are we here today, on Tuesday afternoon at almost 5 o'clock? Because the Senate is in a 30-hour debate about whether we are going to be willing or able to proceed. We are not even on the bill yet; we are in a procedural mode which requires us to have a vote to proceed to consider whether we are going to have a debate on this bill, S. 1955, a bill that changes the choices of the uninsured population in America.

The choices they have today are nothing and nothing. Under any scenario, you would have unanimous support to change that. But there are actually people who are against that up here, but not across the country. As a matter of fact, in this poll done by Public Opinion Strategies in March of this year, over 80 percent of the people polled overwhelmingly support small business health plans; in other words, they support this legislation—the effort to bring new choices of products that are affordable to small businesses, to employers, and, more importantly, to the employees they hire.

In North Carolina, we have 671,000 small businesses. Ninety-eight percent of firms with employees are small businesses in North Carolina. Don't let anybody come to the floor and tell you that this bill does not have an effect except on a select group of people. It may be a select group of people, but it is 98 percent of the employers of North Carolina. Women-owned small businesses have increased 24 percent in North Carolina since 1997, Hispanic-owned small businesses have increased 24 percent since the same date, Black-owned small businesses have increased 31 percent since 1997, and Asian-owned small businesses have increased 74 percent since 1997. These are companies which benefit from this legislation. These are companies which today can't afford the premium costs of health insurance; therefore, their employee base goes without. They are in that category of uninsured that so many people come and talk about on this floor, but they talk about uninsured without the solution as to how to cover them.

This is a population which in some cases today is on Medicaid. They work full-time. Their income level qualifies them for Medicaid. And what would be the incentive for them to get off of Medicaid? It would be if their employer has the option to offer them health care the way the majority of America is now provided health care: through their employer. But we are here in 30 hours of debate trying to decide whether we are going to allow Members to come to the floor and debate a bill and offer amendments which will allow us to switch from nothing and nothing to nothing and something, which will allow us to inject something, some ray of hope into the millions of Americans who don't have coverage today.

Let me read a few letters. I think it is always helpful to hear from people whom this affects, the human face behind the issues that sometimes we lose on this floor simply because we don't want to talk about names or pictures.

This is a woman from Sunbury, NC. She wrote me in mid-April of this year. I am just going to read some pieces. She says:

> Support SBHP legislation, S. 1955. I feel that this is very important because I haven't had health insurance in many years, because my employer doesn't have access to affordable insurance to offer us.

Some suggest on this Senate floor that is not the case, that everybody has the opportunity to have health insurance. ''I haven't had health insurance in many years.'' Why? ''Because my employer can't afford what is available.''

Another letter received in April of this year from a young lady in Elizabeth City, NC:

> Please support Senate bill 1955, the Health Insurance Marketplace Modernization and

Affordability Act. My employer cannot afford health insurance for their employees. My husband works for Ford. They are closing his plant soon. We will have no insurance unless my employer offers it. I have premature twins. They were born 3 months early. It costs me $2,000 a month to feed them. That does not include any doctor's appointments we have to go to. I feel that this is a great bill.

What is America looking for? They are looking for hope. They are looking for us to produce a product out of this institution that actually fulfills their needs. I don't know how it can be any clearer.

It is not offered to me today, because my employer can't afford the options that are in our marketplace.

What do we do? We create new options that are affordable. That is, in fact, what the chairman is trying to do with this bill.

Here is a third letter, also from Elizabeth City but a different business. It says:

Small businesses need help with insurance—

In big bold letters—

I am now paying $986 per month for my wife and myself. This is for only 60 percent coverage and a $2,500 deductible. I know people with group insurance who are paying $600 a month for 80 percent coverage and a $250 deductible. Many of those have dental insurance as well. My policy provides none. Please vote for this bill. Allow small businesses to have coverage equal to employers of other companies.

That is all we are doing. We are using the scale of what people who have a tremendous amount of employees can do, and that is they can go to insurance carriers and they can negotiate for products based upon the volume of their employees. But how does a small business owner do that when he has five or six or seven employees? Well, it is real simple. We allow them to band together. We allow them to band together into a common association, and we allow that association to then market their entire association based upon the volume.

Another letter that I received on April 6 says:

As a small business owner, it is important to enable some economy of scale in allowing franchises to obtain more affordable health care coverage.

The last one I am going to read is quite unique.

As a professional photographer, I have seen firsthand the difficulty that my fellow professional photographers face when attempting to purchase health insurance on their own. S. 1955 would allow photographers and other independent business owners to band together across State lines and purchase health insurance. Having this as an option and choice will improve our access to quality health care and help control costs through competition.

These letters are from people on the front lines. They are from employees whose employers can't offer coverage today because it is not affordable. They are from individuals who own businesses and would like to offer coverage to their employees. They are even from photographers, people whose lives are in their hands every day in a camera, but they cannot afford the individual costs of health insurance in today's marketplace.

In North Carolina, we have 1.3 million uninsured North Carolinians. Of that 1.3 million, almost 900,000 uninsured individuals are in families or are on their own where one person at least works full-time. With the passage of this bill, 900,000 of the 1.3 million uninsured in North Carolina could potentially be offered health insurance. We can narrow it down from 1.3 million to 400,000 individuals who are uninsured in North Carolina with the passage of one simple bill, or at least they would have the option to be able to purchase it for once. Ninety-one percent of workers in large firms of 1,000 employees or more have health insurance, yet 66 percent of workers in small businesses defined as 10 employees or fewer have health insurance. Well, if you remember the North Carolina numbers, I said 98 percent of firms with employees were small businesses. Think of the millions of Americans who are going to be touched by the passage of this one piece of legislation that provides them choice. Where today their choice is between nothing and nothing, tomorrow their choice is between nothing and something.

Why are we here? We are here for 30 hours of debate—not debate on the bill, not debate about the amendments, debate about whether we are going to move forward. We do that at a time when—I just went back and did a quick calculation on the back of my calendar—we have 76 legislative days left between now and adjournment. That is assuming we have productive days on Fridays and Mondays, and as the chairman knows, Fridays and Mondays are not always productive in the Halls of Congress. People are either slow to get here or quick to leave. If you take out Fridays and Mondays, we are down to 45 days. But we are going to spend 30 hours trying to decide whether we are going to move forward to debate this bill, and we will spend another 30 hours after we file cloture on the bill to get to a point where we can have an up-or-down vote, if, in fact, we get that far.

Last night, we voted on two medical liability bills—medical liability that covers the entire medical professional world—and last night, we were denied the ability to proceed and to debate the legislation, much less amend it. The second bill is legislation in which—and I think the American people would be shocked at this—we were denied the ability to move forward to debate or amend legislation that limited the liability to OB/GYNs in America, a specialty we are losing specialists out of every day, where every year people aren't continuing to practice. But we will spend 30 hours debating whether we proceed to debate not necessarily the merits of the bill—and my hope is that the chairman will be successful, and I will be beside him arguing every step of the way, because without this, these Americans don't have hope of a choice of anything other than nothing and nothing.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. ISAKSON). Under the previous order, the Senator from California is recognized.

Mrs. BOXER. Mr. President, my understanding is that Senator DORGAN had time at 5 o'clock set aside, so if he wishes to take it now, then I will wait until his conclusion.

I ask unanimous consent that at the conclusion of Senator DORGAN's remarks I be permitted to speak at that time. Since it is controlled by the Democrats, I can make that request by myself.

The PRESIDING OFFICER. The Senator from North Dakota will be recognized, and at such time as he completes his statement, the Senator from California will be recognized.

Mr. ENZI. That is assuming it comes within the 30-minute parameters?

The PRESIDING OFFICER. The Senator is correct.

Mr. DORGAN. Mr. President, I have listened to some of the debate today. It has been very interesting. The last speaker spoke about choice and choices. I want to talk about choices in health care a bit. This is Health Week, we are told. It is an opportunity, for a change, at long last to talk about some health care issues on the floor of the Senate.

The intent, I believe, of the chairman who brings this bill to the floor is that we should speak only about and address only the issues dealing with small business health plans. However, he knows and I know there are many other health issues that have been long delayed by this Chamber and that need to be debated. I intend to offer a number of amendments. They are in order under the rules of the Senate. They are amendments that deal explicitly with health care issues.

The issue before the Senate is not unimportant. The question of rising health care costs is very significant to everybody—individuals, businesses, governments. Everyone who is a consumer has to deal with increased costs of health care and we should, indeed, address the issue of health care costs for business associations and for small businesses. There is no question about that. I wish to be a part of the group that works on that in a bipartisan way, in a way that expands opportunity, not narrows opportunity; in a way that expands coverage, not narrows coverage; in a way that covers everyone, not just a few. I do not agree that we should make health care unaffordable for the older and sicker and then make profit out of insuring people who are younger and healthier. That is not the right way to do this.

But having said all of that, let me describe some other things that have been long delayed on the floor of the Senate that need to be addressed. Let me talk about the first one. It is the

issue of reimportation of prescription drugs. A bipartisan piece of legislation has been long ago introduced and discussed here on the floor of the Senate, and we have not had the opportunity to vote on it.

The reimportation of prescription drugs, why is that important? Because the American people are charged the highest prices in the world for prescription drugs; it is not even close—the highest prices in the world. Consumers in every other country are paying lower prices. Try to buy Lipitor and if you buy it in the United States you pay a higher price than in any country in the world—France, Germany, England, you name it. You pay the highest prices in the United States. Why should U.S. consumers be charged the highest prices?

With consent, I want to show a couple of things on the floor of the Senate. Let me show, if I might, two bottles of Lipitor. I ask consent to show these on the floor of the Senate.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DORGAN. As you can see, they look identical: identical labels, identical pills in the same bottle made by the same company—shipped to two different places. One is shipped to Canada and one is shipped to the United States. The difference? One is half the price of the other. Guess which. It is the Canadian consumer who gets the benefit of paying half the price for the identical prescription drug.

Let me also show a couple of containers of Prevacid. This is a drug that is widely used for ulcers. Once again, as you can see, it is essentially the same bottle, same pill, made by the same company, made in an FDA-approved plant and shipped to two different locations, one to Canada and one to the United States. The difference? This one costs twice as much. Who buys this one? The U.S. consumer; twice as much for the same pill.

An old fellow sitting on a hay bale in North Dakota at a farm meeting said, my wife has been fighting breast cancer for 3 years. She took Tamoxifen for breast cancer. Every 3 months we drove to Canada to get Tamoxifen because it was the only way we could afford it, and we paid about 80 percent less than it would have cost us to buy that prescription drug to treat her breast cancer. We paid 80 percent less by driving to Canada to get it.

The fact is, they allow a small amount of drugs to come across the border for personal use. But other than that, a U.S. consumer cannot access an FDA-approved prescription drug nor can a U.S. pharmacist access that same FDA-approved prescription drug. That is unbelievable. We have a bipartisan group of Members of the Senate who say consumers ought to be able to purchase FDA prescription drugs by reimporting them from other countries. That would put downward pressure on prescription drug prices in this country. A bipartisan group of Senators wants to do that, but we are prevented from doing it by current law. We want to change the law.

Yet we are prevented from changing the law because the majority leader won't bring this legislation to the floor of the Senate. This is something we can offer as an amendment to the bill on the floor. It is well within the rules of the Senate, it deals with health care, and I am serving notice now that this is an amendment we will offer and vote on during the conduct of this discussion, providing we are allowed to offer amendments. I am hearing rumors that perhaps the majority leader will decide to fill the tree legislatively and allow no amendments. If that is the case, it will be a long week, but my hope is he will not do that. If amendments are allowed, I will offer this amendment and will get a vote.

Let me go back to about midnight on the night of March 11, 2004. That is a little over 2 years ago—midnight. The reason I remember it was midnight, I was sitting right back here and I reached an agreement with the majority leader, Senator FRIST. Here is what Senator FRIST announced that evening after our negotiations, and after which I agreed to release the name of Dr. Mark McClellan to be promoted from the head of FDA to the Centers for Medicare and Medicaid Services. As a result of that, Senator FRIST came to the floor and put this in the RECORD.

> I announce for the information of my colleagues that, with consultation with the chairman of the Senate Committee on Health, Education, Labor, Pensions, Senator DORGAN, Senator STABENOW, Senator MCCAIN, Senator COCHRAN, and other interested Senators, the Senate will begin a process for developing proposals that would allow for the safe reimportation of FDA-approved prescription drugs.

Two years later, nothing: No vote on the floor of the Senate, nothing. My colleague, Senator VITTER, sent a letter around a year ago. It says:

> . . . in the context of the Lester Crawford FDA nomination, I obtained an agreement with Majority Leader FRIST regarding drug importation legislation. . . .The Senate will probably hold some floor vote on a reimportation amendment soon, probably on the Agriculture Appropriations bill. Should that vote demonstrate that reimportation has 60-vote support on the floor, then Leader FRIST will be open to and work in good faith toward a floor debate and vote on a reimportation bill. . . .

What happened as a result of that? Nothing. No action, no votes, nothing.

This bill on the floor of the Senate is amendable. This bipartisan amendment deals with health care. It has been long delayed—and no more. I intend to offer this amendment this week.

Finally, at long last, perhaps the American consumers will no longer be charged the highest prices in the world for prescription drugs because they will be able to access FDA-approved drugs by reimporting them from virtually any other country in which the consumers are paying a lesser price for the identical prescription drug. That is unfair to the American people. The only reason we have not changed it yet is there are, regrettably, a few people in this Chamber who have blocked that opportunity, I assume on behalf of the pharmaceutical industry. But that blocking is about done. This week this bill is open for amendment. I intend to come and offer this as an amendment.

That is one.

Let me talk for a moment about another issue, once again long promised here to the Senate. We are told we are going to have an opportunity to do this—again and again and again—and we are not. We don't get the opportunity. It is called stem cell research. It is controversial; there is no question about that. I understand the controversy. But is it important? Yes, it is. We have all these people who talk about life. This is about life. This is about life-giving medical research, to find ways to unlock the mysteries and to cure some of the worst diseases known to people: Alzheimer's, diabetes, cancer, heart disease, Parkinson's. There is an unbelievable opportunity for medical research to unlock the cures for some of these diseases. But we need to proceed with stem cell research.

We have been long promised the opportunity to have a vote on stem cell research on the floor of the Senate, and guess what. No such vote. On May 24, almost 1 year ago, the House of Representatives passed a bill on stem cell research. We are still waiting to have a vote on that here on the floor of the Senate—once again, a bill with bipartisan support.

Let me describe, if I might, the importance of this in the eyes of a young woman. I met with this young girl about 2 weeks ago. It is not the first time I met her. She is a young lady, Camille Johnson, 13 years old, diagnosed with type 1 diabetes at age 4. She is the one in the middle, playing the clarinet. She has had some very serious health problems, some very serious problems in her young life. She would like very much to live her life without diabetes. She would like diabetes to be cured for her and millions of others.

In 2002, scientists at Stanford University used special chemicals to what is called transform undifferentiated embryonic stem cells of mice into cell masses that resemble islets found in the mouse pancreas. When this tissue is transplanted into the diabetic mice, it produces insulin in response to high glucose levels in animals. Wouldn't it be wonderful if, through this stem cell research, we cure diabetes; if we could tell this young woman your life is not going to be a life of diabetes. We can cure that disease.

I have been involved in political campaigns recently and have been told by opponents that my proposal and my position on stem cell research is one that

murders embryos. Nothing could be further from the truth, nothing at all. Do you know there are 1 million people living among us, walking, breathing, talking—1 million people who were conceived through in vitro fertilization? One million people. When that in vitro fertilization takes place, the uniting of a sperm and an egg in a petri dish, more than a single embryo is created. A number of embryos are created in that process. Some are implanted into the uterus of a woman and some become a human being. Some are cryogenically frozen and stored in the event they should be used again if this did not result in a pregnancy.

There are some 400,000 of those embryos frozen at in vitro clinics right now, 400,000 of them, and 8,000 to 11,000 are discarded, thrown away, every year. They become hospital waste.

Should some perhaps be used for stem cell research with the hope of saving lives? The answer clearly is yes. This is not about murdering an embryo. If in fact this is the murder of an embryo, then the discarding of the embryos at the in vitro fertilization clinic, 8,000 to 11,000 a year, is also murder.

We had one person testify at the Commerce Committee a couple of years ago who said those 1 million people who are here as a result of in vitro fertilization should not be here; it was wrong to create these people. Tell that to the parents who had those children; the childless parents who, through in vitro fertilization, discovered the miracle of having a child.

The question of stem cell research is not about murdering an embryo, it is about an opportunity to cure some of the dreaded diseases.

The other issue—and the reason I am talking about this is this is a big issue that we are not allowed to vote on in the Senate. This, too, should be an amendment on this bill. This, too, during Health Week is a very important issue dealing with health.

The other side of this research is something called somatic cell nuclear transfer. Simply it is this: Let us assume a patient takes a skin cell from their own earlobe and that skin cell from their earlobe is then put in an evacuated egg and stimulated to become a blastocyst of a couple of hundred cells.

That blastocyst now has predictor cells. They use the predictor cells for heart muscle, to inject back into the heart muscle to grow a stronger heart, to repair a heart attack.

Some would say you have destroyed or murdered an embryo. There is no fertilized egg. There is only the skin cell from the person who had the heart attack whose cell is now being used, through somatic cell nuclear transfer, to save that person's life. This is about lifesaving. Yet we have so many here who said: Let's not worry about these diseases. Let's shut off this research because we think it is about murdering embryos.

That is not what this is about. It is about this young girl and whether we decide we want this young girl to live her life as a diabetic, a life filled with hope at this point that Congress will finally do the right thing.

The House of Representatives did it. The Senate needs to vote on it. Perhaps this week is as good a week as any. We have been promised. A year ago we were promised, just like drug reimportation. This Chamber is full of promises, but we never quite get to vote on important issues.

I am not suggesting that when I talk about stem cell research that there are not ethical considerations, without serious concerns and serious issues to which we should be attentive. We should. I don't dismiss all the other concerns. But I do say this: If you have lost a child, if you have lost a loved one, and you have watched someone die from Parkinson's or cancer or heart disease, if you have been through that and then say to yourself: But I want to shut down promising research that could potentially cure diseases, then you have not been through it the way a number of people in this Chamber have been through it. I think it is so important for us to do the right thing and to continue this breathtaking research that can save lives.

There are so many other issues. There are just a couple of minutes remaining. Then I will yield the time to my colleague from California.

We passed recently in the Senate a piece of legislation that provides prescription drug benefits to senior citizens. But we did nothing to put downward pressure on drug prices. There is a special provision in the bill which my colleagues, Senators WYDEN and SNOWE, were talking about earlier today, that actually prevents the Federal Government from negotiating for lower prices with the pharmaceutical industry. That is unbelievably ignorant. A provision like that is unbelievably ignorant, and it ought to be repealed.

All we need is a vote on that on the Senate floor. That, too, is a health issue. There is no excuse for this Congress to say: By the way, the Federal Government cannot negotiate for a lower price. We already do it in the VA. We end up with far lower prices as a result of the negotiations.

In this case, with this bill, there is a provision that says: Don't you dare negotiate. It would be against the law for you to try to get lower prices and reduce Government spending. That, too, is a health issue. That, too, will be in order this week.

I hope very much that we will have a vote on that. Yes, the underlying bill is important. We ought to find a bipartisan way to fix it. No, it doesn't work the way it is. It will restrict choice, in my judgement, increase prices for some, and make others completely uninsurable. We ought to fix it in a bipartisan way.

But on the other three issues—reimportation of prescription drugs, stem cell research, repeal the law that prevents negotiation of lower prices with the pharmaceutical industry to save taxpayers money—shouldn't we do all three of those? We ought to do all three of those this afternoon, right now. We have been blocked for far too long.

If there is, in fact, an amendable vehicle—and I hope it will be; we will know that tomorrow morning—then I have just described three amendments that I believe should be offered, and when offered I believe will be approved in the coming days. If not, if this is a charade, and tomorrow we discover there is a legislative approach called ''filling the tree,'' which is simply setting up a little blocking device to say we are not going to allow anybody to offer anything, then I think the Senate will have sent a very strong message that this isn't Health Week. This is a week in which you want to trot out a little proposal of your own and avoid votes on serious issues that we should be taking in the Senate.

I yield the floor.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, I appreciate Senator DORGAN's remarks. I have been on the floor of the Senate a lot today waiting to get the time, and I have been fortunate to hear many colleagues. I thank him for very succinctly pointing out that in a real health care week you wouldn't close your eyes to hope—hope that we are going to find cures for the terrible diseases that plague our families—Parkinson's, Alzheimer's, diabetes, spinal cord injuries, stroke, heart attack, you just name them. The fact is, we know stem cell research is promising. We know a lot of States have gotten out ahead of the Federal Government because this President and this Congress have restricted the number of stem cell lines we can fund research on. And many of those stem cell lines are, frankly, no good at all because they have been impacted by mice cells. And they lack the diversity needed for robust research.

I have talked to leaders in this field. I am not a scientist. I was educated in economics. But I have spoken to leading scientists, among whom is a gentleman named Dr. Peterson who worked at USFC in San Francisco. He is one of the leading pioneers in stem cell research who left to go to England because this President and this Congress put up a big stop sign in front of stem cell research. It is tragic.

Our families need the hope of a cure. How many of us have met with these youngsters who have juvenile diabetes, and we have seen how difficult their lives are and how they suffer, even with the strides that have been made in this area. They are still in great danger.

Health Week is here. We have a vehicle, as Senator DORGAN calls it, the Enzi bill, which tries to deal with the health insurance problems that small businesses face. I am going to talk about a better alternative to the Enzi

bill that will really do something. But we also have a chance to raise these issues during the debate on the Enzi bill.

We have bipartisan support for drug importation from countries such as Canada, where drugs are sold at half the price of what drug companies charge in the U.S. We have bipartisan support for stem cell research, fixing the Medicare prescription drug issue so we could actually say to Medicare: You have the ability and the right just as the VA has to negotiate with the pharmaceutical companies for lower prices. But I have to say Health Care Week Republican style is really Insurance Company Week.

If you look at the bills that have been brought before us, they all help the insurance companies. They don't help average Americans. They do not help us.

The first two bills said we are going to restrict the right of patients—whether they are very wealthy, whether they are middle income, whether they are poor—we are going to stop them from recovering damages if they are harmed by medical malpractice.

I was very pleased that the Senate chose not to limit debate on those two bills which would have taken away the rights of patients while giving a gift to the insurance companies. And hopefully we can change the Enzi bill.

I don't like bills that take away benefits from my people in California. I don't like bills that take away benefits from all Americans. That is why the Enzi bill is a bad bill. It does just that. I will go through with you the list of benefits that are taken away.

Mr. President, the Republicans bring us Health Care Week. They bring us the Enzi bill. What they do not tell us and you don't find out until you look is that all the States' protections that have been put into place will be wiped out upon passage of the Enzi bill.

Those are harsh words. What do I mean? What benefits will be taken away from my people in California? According to the report put together by Families U.S.A, ''The Enzi Bill, Bad Medicine for America,'' those benefits include AIDS vaccines, alcoholism treatment, blood lead screening. You know that is important because if you don't screen kids for lead in their blood they could have learning disabilities—bone density screening. We know about osteoporosis. In California we guarantee that your insurance will pay for that; no guarantee in the Enzi bill whatsoever. As a matter of fact, the Enzi bill overrides all of this—cervical cancer screening, clinical trials, colorectal screening, contraceptives, diabetic supplies and education.

We just talked about how it is so important for diabetics to have their meds—drug abuse treatment, emergency services, home health care, hospice care, infertility treatment, mammography screening, maternity care, mental health parity.

In my State, if you have a mental health problem and you need help, your insurance coverage will cover your treatment, just the same as if you had a physical problem. We know it works. The list goes on—metabolic disorders, minimal mastectomy, off-label drug use. In California, we have a law that says you can't kick a woman out of a hospital the same day she has a mastectomy. What, you may say? This happens? It does—off-label drug use, orthotics, prosthetics, prostate cancer screening. We know that prostate cancer is a scourge—reconstructive surgery, second medical surgery opinion.

If somebody tells you you need serious surgery, you can get a second opinion in California. That is covered—special footwear, telemedicine, well child care, so that we prevent diseases. That is my State.

Every single State in the Union gets overridden, whether it is Alabama, Colorado, Georgia, Idaho.

I know my friend from Georgia would be interested because he is sitting in the Chair. These are the things that your State offers. It protects your consumers. It is as long a list as California, I am proud to say—alcoholism treatment, ambulatory surgery, bone density screening, bone marrow transplants are covered in the State of Georgia. Cervical cancer screening, contraceptives, dental anesthesia, diabetic supplies, drug abuse treatment, emergency services, heart transplants are covered in Georgia. Infertility treatment, mammography screening, mental health parity, minimal mastectomy stay, morbid obesity care—which is very important now with the obesity epidemic—off-label drug use, ovarian cancer screening, telemedicine, and well child care. Georgia has a very inclusive and wonderful list of guaranteed protections for people.

In the State of Georgia there are 2.347 million people affected by this who would not have those guarantees under the Enzi plan. The Enzi plan essentially says to insurance companies: You can choose. You have to offer one plan. What do they call that plan? One premium plan. You have to offer one premium plan based on a state plan of their choosing, but there is no guarantee at all that what is in that premium plan is what is in the Georgia plan or the California plan or the North Dakota plan.

The fact is, all of the work that has been done in our States—and I find it somewhat amusing given this is a Republican debate, that the Republican bill preempts the States. What is wrong with this picture? I thought our Republican friends loved decisionmaking at the State level. No, not here in the Senate. They would prefer the insurance companies decide it rather than the States.

This is why I call my colleagues' attention to a study done on the impact on all the States, with letters compiled from attorneys general from many of the States and Governors.

From Oregon, they register their opposition, first their benefits are not guaranteed any longer. In addition, they are very worried about what happens to premiums. The Enzi bill disadvantages older people. As far as the research I have done, it disadvantages women. It certainly disadvantages people who come in with a preexisting condition such as high blood pressure. That includes a lot of Americans.

The bottom line is, the Enzi bill, the star rollout production of the Republican Health Care Week, will make null and void all protections that our States have given their citizens and replace them with some kind of riverboat gamble where insurers will choose some plan, from some State, and apply it to my State. I don't want a so-called premium plan from another State.

Here is a good example. In Connecticut, there is a terrible epidemic of Lyme disease. A tick bites your body and it can make a person very ill. We have some of that in California, but we do not have as much per capita as Connecticut. In Connecticut, the State legislature and the Governor say insurers have to cover Lyme disease because it is an epidemic in the State. In other States, it may not be necessary. However, we will wipe that Connecticut requirement off the books, and we will say, through the Enzi bill, insurance companies are going to decide.

Something is wrong. This is not Health Care Week, this is ''insurance company week.'' That is not good for consumers.

My own State has built a comprehensive State health insurance system that encourages affordable and equitable coverage for all, while ensuring consumers are protected and guaranteed benefits. The Enzi bill takes away a State's power to regulate health insurance. It is a gift to the insurers, as I said. It preempts benefits, as I said. It also is going to lead to way higher premiums for all in America who are covered by health insurance.

Insurance companies, not the States, will now decide what benefits the consumers. That is why we have letter after letter after letter from Governors, from attorneys general, warning us not to pass the Enzi bill.

There appears to be no limits on the cost shares an insurer can charge nor are there requirements that plans treat consumers equitably or offer comprehensive coverage.

As I said, if you are a little older—maybe you have high blood pressure, maybe you have some other health problems—you are in trouble. You are not going to have an affordable plan and you will lose the benefits you have. You may be priced out of the market. It will be catastrophic.

We have serious problems with the Enzi bill. Here is the great news. There is a wonderful alternative out there, the Durbin-Lincoln bill, of which I am a cosponsor. I thank my friends for working so hard on this.

As I go around my State, people nod in agreement with the Durbin-Lincoln bill's premise. Senators have very good

health insurance. We pay half of the premium and the Government matches the other half. There is a Federal Employee Health Benefits Program. There are basic benefits required and private companies come in and offer various plans. People such as me and my employees can choose from a broad array of plans. It works beautifully.

I ask unanimous consent, at 5:45, the Senator from Oregon, Senator MURRAY, be recognized for 15 minutes, until 6 o'clock.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. BOXER. Senators DURBIN and LINCOLN take this Federal plan and open it up to small businesses with 100 employees down to a single self-employed person.

This plan will work because there will be a huge pool set up. Everyone can buy into it from any business in this country with less than 100 employees. It would be a very diverse pool of people. They will be insured. The pricing is going to be very fair and reasonable. The plan will be administered in the same way our Federal benefits are administered.

I heard Senator THUNE say: That is a government plan. No, it isn't. It is a plan that is administered by the Federal Employees Health Benefit Plan, but it is coverage provided by private insurers. Because the administrative costs are kept so low, this is going to be very affordable and will solve the problem.

And guess what. This alternative, the Durbin-Lincoln alternative, does not take away the protections States have given all who live in those States. If you are in California, you still get the benefits. By law, you are protected. If you live in Washington State, you will get those benefits. The alternative that the Democrats are behind will cost less. It will protect benefits. It will work beautifully.

I say to my colleagues, if it is good enough for you, it ought to be good enough for small businesses and their employees. This bill is a wonderful and practical alternative.

In my concluding 6 or 7 minutes, I will say that this so-called Health Care Week is a major disappointment, unless we find out tomorrow we can amend the Enzi bill. If we can amend Enzi and pass stem cell research and prescription drug reimportation, if we can make sure there is hope for patients with Alzheimer's, diabetes, heart condition, stroke, cancer because we move ahead with science, then Health Care Week will have mattered. If we can offer the Durbin-Lincoln substitute, it will not preempt the protections of State law as the Enzi bill does. The Enzi bill has more opposition than any bill I remember. AARP is against it. The Cancer Foundation is against it. There are 224 organizations against it.

I ask unanimous consent to have printed in the RECORD those organizations opposed to the Enzi bill.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

National Partnership for Women & Families, 9 to 5, Association for Working Women, Action Alliance of Senior Citizens of Greater Philadelphia, Alabama Psychological Association, Alliance for Advancing Nonprofit Health Care, Alliance for Justice, Alliance for the Status of Missouri Women, American Academy of Child & Adolescent Psychiatry, American Academy of HIV Medicine, American Academy of Pediatrics.

American Academy of Pediatrics—Nebraska Chapter, American Academy of Physician Assistants, American Association for Geriatric Psychiatry, American Association for Marriage and Family Therapy, American Association of People with Disabilities, American Association on Mental Retardation, American Chiropractic Association, American College of Nurse-Midwives, American Counseling Association, American Diabetes Association.

American Federation of State, County and Municipal Employees, American Federation of Teachers, American Foundation for the Blind, American Nurses Association, American Occupational Therapy Association, American Optometric Association, American Pediatric Society, American Podiatric Medical Association, American Psychiatric Association, American Psychological Association.

American Speech-Language-Hearing Association, Arizona Action Network, Arizona Business and Professional Women, Arizona Psychological Association, Asociacion de Psicologia de Puerto Rico, Assistive Technology Law Center, Association of Medical School Pediatric Department Chairs, Association of University Centers on Disabilities, Association of Women's Health, Obstetric and Neonatal Nurses, B'nai B'rith International.

Bazelon Center for Mental Health Law, C3: Colorectal Cancer Coalition, California Coalition for PKU and Allied Disorders, California Black Health Network, California Psychological Association, Campaign for Better Health Care—Illinois, Capital District Physician's Health Plan, Inc., Catholics for a Free Choice, Center for Civil Justice, Center for Justice and Democracy.

Center for Women Policy Studies, Children's Alliance, Citizen Action/Illinois, Citizen Action of New York, Clinical Social Work Guild 49, OPEIU, Coalition on Human Needs, Colorado Center on Law and Policy, Colorado Children's Campaign, Colorado Progressive Action, Colorado Psychological Association.

Committee of Ten Thousand, Communications Workers of America, Connecticut Citizen Action Group, Consumers for Affordable Health Care, Delaware Alliance for Health Care, Delaware Psychological Association, Department for Professional Employees, AFL–CIO, Disability Rights Wisconsin, District of Columbia Psychological Association, Easter Seals.

Empire Justice Center, Epilepsy Foundation, Excellus Blue Cross Blue Shield, Families USA, Families with PKU, Family Planning Advocates of New York State, Florida Consumer Action Network, Georgia Rural Urban Summit, Guttmacher Institute, HIP Health Plan of New York.

Hawaii Psychological Association, Health and Disability Advocates, Hemophilia Federation of America, Idaho Psychological Association, Illinois Alliance for Retired Americans, Illinois Psychological Association, Indiana Psychological Association, Institute for Reproductive Health Access, International Association of Machinists & Aerospace Workers, International Brotherhood of Electrical Workers.

International Longshore & Warehouse Union, Iowa Citizen Action Network, Iowa Psychological Association, Kansas Psychological Association, Kentucky Task Force on Hunger, League of Women Voters, Maine Children's Alliance, Maine Dirigo Alliance, Maine People's Alliance, Maine Psychological Association.

Maine Women's Lobby, Massachusetts Psychological Association, Maternal and Child Health Access, Mental Health Association in Michigan, Mental Health Legal Advisors Committee (Commonwealth of Massachusetts), Michigan Association for Children with Emotional Disorders, Michigan Campaign for Quality Care, Michigan Citizen Action, Minnesota COACT, Minnesota Psychological Association.

Missouri Association of Social Welfare, Missouri Progressive Vote Coalition, Montana Psychological Association, Montana Senior Citizens Association, Inc., NAADAC—The Association for Addiction Professionals, NETWORK, a National Catholic Social Justice Lobby, National Alliance on Mental Illness, National Association for Children's Behavioral Health, National Association of Anorexia Nervosa and Associated Disorders, National Association of Social Workers.

National Association of Social Workers, Arizona Chapter, National Association of County Behavioral Health and Developmental Disability Directors, National Coalition for Cancer Survivorship, National Consumers League, National Council for Community Behavioral Health Care, National Council of Jewish Women, National Council on Independent Living, National Disability Rights Network, National Family Planning and Reproductive Health Association, National Health Care for the Homeless Council.

National Health Law Program, National Hemophilia Foundation, National Mental Health Association, National Multiple Sclerosis Society, National Organization for Women, National Rehabilitation Association, National Research Center for Women & Families, National Urea Cycle Disorders Foundation, National Women's Health Network, National Women's Law Center.

Nebraska Psychological Association, Nevada State Psychological Association, New Hampshire Citizens Alliance, New Jersey Citizen Action. New Jersey Psychological Association, New Mexico PACE, New Mexico Psychological Association, New York Civil Liberties Union Reproductive Rights Project, New York State Health Care Campaign, New York State Psychological Association.

North Carolina Justice Center's Health Access Coalition, North Carolina Psychological Association, North Dakota PKU Organization, North Dakota Progressive Coalition, North Dakota Psychological Association, Northwest Health Law Advocates, Northwest Women's Law Center, Ohio Psychological Association, Oklahoma Psychological Association, Oregon Action.

Oregon Advocacy Center, Oregon Psychological Association, Organic Acidemia Association, Patient Services, Inc., Pediatrix Medical Group, Pennsylvania Council of Churches, Pennsylvania Psychological Association, Philadelphia Citizens for Children and Youth, Philadelphia Coalition of Labor Union Women, Planned Parenthood Federation of America.

Planned Parenthood of New York City, Population Connection, Progressive Maryland, Public Citizen, RESULTS, Religious Coalition for Reproductive Choice, Reproductive Health Technologies Project, Rhode Island Ocean State Action, Rhode Island Psychological Association.

Sargent Shriver National Center on Poverty Law, Save Babies Through Screening Foundation, Senior Citizens' Law Office,

Small Business Majority, Society for Pediatric Research, South Dakota Psychological Association, Suicide Prevention Action Network USA, Summit Health Institute for Research and Education, Inc., Tennessee Citizen Action, Tennessee Psychological Association.

Texas Psychological Association, The Arc of the United States, The Black Children's Institute of Tennessee, The Disability Coalition of New Mexico, The Institute for Reproductive Health Access, The Senior Citizens' Law Office, The Virginia Academy of Clinical Psychologists, Triumph Treatment Services, US Action, US Action Education Fund.

U.S. PIRG (Public Interest Research Group), Union for Reform Judaism, United Association of Journeymen and Apprentices in the Plumbing and Pipe Fitting Industry, United Cerebral Palsy, United Food and Commercial Workers, United Senior Action of Indiana, United Steelworkers International Union, United Vision for Idaho, Univera Healthcare, Universal Health Care Action Network.

Utah Health Policy Project, Vermont Coalition for Disability Rights, Vermont Office of Health Care Ombudsman, Voices for America's Children, Voices for Virginia's Children, Washington Citizen Action, Washington State Coalition on Women's Substance Abuse Issues, Washington State Psychological Association, West Virginia Citizen Action Group, West Virginia Psychological Association.

Wisconsin Citizen Action, Wisconsin Psychological Association, Women of Reform Judaism, WorId Institute on Disability, Wyoming Psychological Association.

Mrs. BOXER. Mr. President, this bill is going to hurt American health care by cancelling out all the hard-won State protections and by raising premiums so high they will price consumers out of the market. That is why across the board there is opposition. I have not seen this many organizations come out against a bill.

By the way, this bill, when it was first presented, sounded reasonable. It was only when we looked at the small print that we realized how dangerous it is.

Instead of working on this misguided bill, we could have done the alternative, we could have done the stem cell, we could have fixed the Medicare prescription drugs, we could have allowed drug importation.

If we didn't want to do real health care reform, there are a lot of other things we could have done, such as raise the minimum wage. We could have finished the job on immigration reform, strengthening the enforcement at the border and stopping illegal immigration, but getting people on a path and out of the shadows.

What about Superfund sites? We have some of the most polluted sites in the country still awaiting cleanup. We have one in four people in America, including 10 million children, living within 4 miles of a Superfund site.

What about debating the war Iraq? That is on everyone's mind. There is still no exit strategy. There is still no plan. We see suffering on the ground there every single day.

We have issues with a potential nuclear Iran. We should debate that. In Afghanistan, the situation is deteriorating and we have all but forgotten about it. We have not followed the recommendations of the 9/11 Commission to this date. We have failed fiscal policies. We have debt as far as the eye can see. We ought to debate pay-as-you-go. If Members want to spend money, they should show how they going to pay for it instead of putting the burden on the backs of America's children.

There are many other things we could do, but since we are on Health Care Week, let's fix our health care system. Let's not pass a bill that will not help people with serious diseases or fix the problems with the Medicare prescription drug program.

We have so much work to do and this Enzi bill is masquerading as a bill that will help our citizens. When we read the fine print, we find out it is only going to make matters worse.

I am proud to yield the floor to my friend from Washington.

The PRESIDING OFFICER. The Senator from Washington is recognized for 15 minutes.

Mrs. MURRAY. Mr. President, I ask unanimous consent the next Democratic speakers in order be Senator DAYTON, Senator DURBIN, and Senator AKAKA.

The PRESIDING OFFICER (Mr. CHAMBLISS). Without objection, it is so ordered.

Mrs. MURRAY. Mr. President, at this hour, families are struggling with health care. Seniors are facing a critical deadline for drug coverage. Businesses are grappling with the high cost of insurance. And patients are being denied the cutting-edge research that could save their lives. Those are critical issues. And what is the Senate doing? We are dealing with a distraction instead of real solutions to make health care affordable, more accessible, and more innovative.

I am on the Senate floor this evening to talk about what we should be doing to help families and businesses and communities meet their health care needs. I also want to talk this evening about why the Republican proposal, S. 1955, could do more harm than good.

This is a bill which takes a good idea—pooling the risk in health insurance—and distorts it with a plan that will raise the cost of health care, strip away patient protections, and hurt many of our small businesses. But do not take my word for it. Attorneys general from 41 States, including my own, have written to outline the serious problems with the Republican bill. I have heard from doctors with the Washington State Medical Association and from my own Governor about the damage this bill will inflict on patients and on our economy.

Simply put, this proposal is a distraction. Instead of dealing with real solutions to real problems, the Republican leadership is wasting time on one narrow proposal that is only going to make things worse. We can do better. The truth is that patients and seniors, doctors and nurses, and all of our communities deserve better.

If we were serious about reducing the cost of health care, helping to improve access, and driving innovation, we would be talking about the critical issues that the Republican leadership is trying to avoid. We should be focusing on everything from the Medicare drug program, to stem cell research, to community health care. Frankly, we do not have a day to waste.

On Monday, millions of seniors and disabled will be hit with a deadline that means higher premiums for their prescription drugs. That May 15 deadline is just 6 days away. I am hearing from seniors that they are very worried about this deadline. They are worried they are going to pick the wrong plan, and they do not think it is fair to be punished if they need more time so they can make an informed choice.

I have been traveling throughout my home State of Washington, meeting with seniors and holding roundtables with patients, with pharmacists, with advocates.

Three weeks ago, I was in Chehalis, at the Twin Cities Senior Center. I can tell you, seniors are worried. They are angry. They are frustrated. They are frightened about this May 15 deadline, and that deadline is just one of the problems this flawed drug program is presenting.

The week before that, I was in Silverdale, and I have held Medicare roundtables in Kent, Vancouver, Ballard, Shelton, Spokane, Anacortes, Bellevue, Aberdeen, Olympia, Lakewood, Seattle, and Everett. Everywhere, I have heard from seniors about just how bad the Medicare Part D Program is. I have heard their frustration about dealing with such a confusing system. I have heard their anger that this program does not meet their needs. And I have heard from many who just want to throw their hands up in the air and ignore the whole program.

If we were serious about improving health care, we would be fixing the problems they have outlined. Instead, we are going to let an unfair deadline hurt our seniors even further. In just 6 days—in just 6 days—they are going to have to pick a plan or face high penalties whenever they do enroll, and the penalties grow larger the longer they wait. To me, that is just not fair.

Right now, this Senate could be extending the deadline so our seniors are not pressured into making the wrong choice in such a complicated system. Right now, we could be lifting the penalty so that seniors are not punished if they need more time to make the right choice. Right now, we could be providing help to millions of vulnerable Americans who have been mistreated by this flawed Republican plan. But, instead, this Congress is leaving seniors to fend for themselves. The Secretary of Health and Human Services has said he opposes extending the deadline or lifting the penalties, and this

Republican Congress seems to agree with him by a shameful lack of action.

Seniors deserve better. The disabled deserve better. Our most vulnerable neighbors deserve better. If we really wanted to make health care more affordable and more accessible and more innovative, we would be on this floor fixing the Medicare drug program and helping seniors who are facing that unfair deadline.

Now, that is just one example of what a real focus on health care on this floor would include.

If we were serious about helping patients, we would be expanding lifesaving research. For patients who are living with diseases such as Parkinson's or multiple sclerosis or Alzheimer's or diabetes, stem cell research holds the potential to help us understand and to treat and someday perhaps cure those devastating diseases.

Nearly a year ago, the House of Representatives passed legislation to lift the restrictions that hold back this promising research. The House of Representatives has acted, but for an entire year the Senate has not. My colleagues, Senator SPECTER and Senator HARKIN, are well known for their leadership on this fight. They were promised a vote on stem cell research, and that vote has still not taken place. Every delay means missed opportunities for patients with devastating diseases.

If this Senate is serious about health care and saving lives, we should be voting on stem cell legislation today. That is why, last week, I joined with 39 other Senators in writing to the majority leader urging him to bring up H.R. 810, the Stem Cell Research Enhancement Act. But instead of real solutions, the Senate is focusing on a distraction. Patients with life-threatening diseases deserve a lot better.

If we were serious about improving health care, we would be investing in local efforts that boost access to health care.

Two weeks ago, through the Johnson & Johnson Community Health Care Awards, I had a chance to honor leaders from across the country who are doing innovative work to break down the barriers to care. If we were serious about improving health care, we would be building more Federal support for their work. Instead, we are moving in the opposite direction.

Perhaps the best example is the Bush administration's 5-year effort to kill the Healthy Communities Access Program, which is known as HCAP. This is a program which helps our local organizations coordinate care for the uninsured. I have seen it make a tremendous difference in my home State. Well, every year since taking office, this Bush administration has tried to kill that successful program. I have been out here on the floor leading the fight for our local communities every year, and most years we have won. But this past year, the White House and the Republican Congress ended the support for Healthy Communities and thus made health care less accessible for families from coast to coast.

If we were serious about improving health care, we would be investing in local programs that make a difference. But, instead, the Republican leadership is focused on distractions. We can do better than that.

So let me take a few minutes to turn to the specific problems with the bill that is before us, S. 1955, and explain why so many experts across this country are warning us that this bill will eliminate critical patient protections, it will lead to unfair premiums and insurance practices, and it will raise the cost of health care.

First of all, this bill will eliminate many of the important protections that keep patients healthy and lower the cost of health care.

In my home State of Washington, we have enacted a number of State patient protections that require health plans to cover services such as diabetic care, mental health services, breast and cervical cancer screening, emergency medical services, and dental procedures. But under this bill, small business health plans or association health plans would not be required to cover those important benefits. Allowing insurers to abandon mandated benefits, many of which are preventive and are diagnostic, will result in a sicker population and higher health costs for everyone.

When this legislation was debated in the HELP Committee, I offered a number of amendments to provide for coverage of several important women's health benefits. Unfortunately, every one of those amendments was defeated. So now, here we are, and we have a bill on this floor that will strip away the protections on which our patients across this country rely.

A new report by Families USA shows just how many families in my home State will be hurt by this bill. That report found that 1,861,000 residents of Washington State may lose protections if this bill is passed. And what could they lose? Emergency services, home health care, drug and alcohol treatment, contraceptives, diabetic supplies and education, hospice care, mammography screening, maternity services, mental health care—the list goes on. I am not going to tell nearly 2 million people in my home State whom I represent that we are going to take a gamble and risk losing those hard-won protections for a plan that will likely raise the cost of health care for many of our families and small businesses.

Secondly, this bill will encourage insurance companies to charge higher premiums for less healthy consumers. This bill will preempt strong laws and protections in our State that limit the ability of insurers to vary premiums based on health status, age, gender, or geography. I am very concerned this will result in adverse selection or what we call cherry-picking, leading to higher premiums for less healthy consumers. In fact, rates will likely become unaffordable for those who need it the most, potentially increasing the number of uninsured Americans.

Now, Mr. President, I would like to share some letters I have received from leaders in my home State who all speak against this flawed proposal. I ask unanimous consent that these two letters be printed in the RECORD following my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mrs. MURRAY. Mr. President, recently I received a letter from the Governor, Governor Christine Gregoire of my home State of Washington, in which she expressed many of her concerns regarding this legislation and its impact on the people who live in my home State.

This chart behind me contains the full text of the Governor's letter. As you can see, she has many serious concerns. I wish to highlight for the Senate some of the main points our Governor has raised with me.

Governor Gregoire alludes to the harmful aspects of this bill, and she says:

> [S. 1955] stands to harm our small group insurance market, which is a critical component of [Washington State's] current health care system. . . .
>
> Instead of promoting more affordable health care, this legislation would cause a serious increase in rates for consumers—possibly two or three times over what they now pay.

Governor Gregoire also warns in her letter to me that:

> [this] bill threatens consumer protections that the state of Washington strives to guarantee to [all of] our residents.

The Governor also warns that this bill:

> would foster a proliferation of health plans that do not cover preventive services that are absolutely vital to the health and well-being of Washington residents. . . .

Mr. President, I would also like to share a letter that I have received from the 9,000-member Washington State Medical Association that wrote to me in strong opposition to S. 1955.

Now, this chart shows the full letter, and I want to read just a portion of it:

> This legislation will have a severe impact on all the consumer health gains that have been made in Washington State over the past decade.
>
> S. 1955 will:
>
> Undermine Washington State's many gains in advancing health care quality;
>
> Pull people from existing insurance coverage rather than attract the uninsured;
>
> Lead to higher costs for consumers;
>
> Strike down Washington's Mental Health Parity law, which took eight years of work to be enacted;
>
> Eliminate other mandated benefits that help consumers such as mammography services; and,
>
> Leave Washington's citizens at risk for unpaid medical bills in the event of an AHP insolvency.

That is from the head of the Washington State Medical Association, which has 9,000 members in my home

State. I think their words should be heeded by the Members of this Senate.

Third, this proposal does nothing to address increasing health care costs.

In fact, it builds on the sorry record of this administration and this Congress in not addressing the rising costs that Americans face. Because of the flaws I mentioned, this bill does nothing to contain those costs. In fact, it could dramatically increase costs for many businesses and families in Washington State. It could well mean that people in the State of Washington who have affordable coverage today could end up worse off than they are right now.

I know my State has been a leader in working to expand access to affordable health insurance for working families and small businesses. Many of the reforms that worked to control costs in my State would be jeopardized if this legislation is enacted. Washington State has a proud tradition of strong consumer protections and integrated managed care that has improved health outcomes and controlled cost increases. We should not jeopardize what my State has fought hard for by dangerous Federal legislation.

I do support the concept of pooling. I believe we can implement policies that provide stability in health insurance premiums. In fact, I am currently working with a number of my colleagues on legislation to create Federal and State catastrophic cost pools to spread out the risks and address what is driving health care costs. We can help spread the risk in ways that will lower costs and still protect patients. The legislation before us could raise costs for consumers and small businesses. We can do better than that.

There are serious challenges facing our country when it comes to health care. This Senate needs to get serious. Instead of focusing on a distraction, we should be helping seniors with prescription drugs. We should be expanding lifesaving research, and we should be supporting community health care. Those are some of the things we should be working on to reduce the cost of health care and to improve access and to accelerate innovation. We can do all of those things, but we need the Republican leadership to get serious if we are going to provide serious solutions. We don't have a day to waste. I hope we can get to work on the real solutions that our American families deserve.

EXHIBIT 1

CHRISTINE O. GREGOIRE,
OFFICE OF THE GOVERNOR,
Olympia, WA, April 27, 2006.

Hon. PATTY MURRAY,
U.S. Senate, Washington, DC.

DEAR SENATOR MURRAY: I am writing with great concern about S. 1955, the Health Insurance Marketplace Modernization and Affordability Act, and its potential to further erode our ability to provide sound health coverage to citizens in Washington State. This bill stands to harm our small group insurance market, which is a critical component of our current health care system. Furthermore, the bill threatens consumer protections that the State of Washington strives to guarantee to our residents. For these reasons, I ask that you oppose the bill in its current form.

When it comes to providing health care, the federal government has been putting an ever-Increasing burden on the states. The Deficit Reduction Act, alone, paves the way to eliminate nearly $50 billion over the next five years for the Medicaid program. Fresh on the heals of signing the Deficit Reduction Act, the President unveiled his Fiscal Year 2007 budget proposal, which proposes eliminating $36 billion from the Medicare program over the next five years. Additionally, the implementation of the Medicare Part D prescription drug program has had enormous impacts on the states. Nearly every state in the Nation—Washington included—felt compelled to step in to ensure that our most needy citizens, our dual eligible population, continue to receive their medications due to fundamental flaws in the Medicare Modernization Act. Against this backdrop now comes S. 1955.

If passed, S. 1955 would establish a small group rating mechanism that would further erode the possibility of pursuing reasonable health care costs in the states. Instead of promoting more affordable health care, this legislation would cause a serious increase in rates for consumers—possibly two or three times over what they now pay. At its worst, the bill could result in the total collapse of our small group insurance market, something we must fight to prevent.

Additionally, I am concerned that S. 1955 would foster a proliferation of health plans that do not cover preventative services that are absolutely vital to the health and well-being of Washington residents, such as mammography, colonoscopies, diabetic care services, and newborn coverage. In 2005, the Washington State Legislature passed, and I signed, legislation providing mental health parity. If Congress passes S. 1955, the bill could also fully abrogate this effort to ensure mental health coverage in Washington State.

It is surprising to me that S. 1955 is moving forward, given that it is patterned, in part, on a flawed National Association of Insurance Commissioner's 1993 Model Rating Law, actually adopted by the state of New Hampshire in 2003. This proved to be an unfortunate experiment for the people of New Hampshire. Just this year, that state's Legislature repealed provisions of its 2003 law due to the astronomical jump in rates that occurred in only a two-year period after it was implemented. Given this history that he knows only too well, my colleague, Governor John Lynch of New Hampshire, recently registered his opposition to S. 1955 in a letter to his federal delegation, dated March 28, 2006. New Hampshire's experience is illustrative and a harbinger of what could come to all states, should Congress adopt S. 1955.

As Washington State's Attorney General from 1993–2005, I, along with the majority of my colleagues within the National Association of Attorneys General (NAAG), opposed several precursor bills to S. 1955. Introduced in each of the last several Congresses, these bills allow for the federal regulation of association health plans (AHPs), and have passed out of the U.S. House more than once. I appreciate that S. 1955, in its current form, does away with one fatal flaw of the earlier AHP bills—that being the wholesale obliteration of state regulation over national AHPs. But, as I have articulated, S. 1955 still goes too far in preempting other basic consumer protections. It is heartening to see that a majority of current members of NAAG, including Washington State Attorney General Rob McKenna, have now weighed in with their concerns and opposition to S. 1955.

As a nation, we need innovative solutions that provide high quality, sustainable and affordable health care access to our un- and under-insured populations. With the help of the Washington State Legislature, I have embarked on a five-point strategy to promote evidence-based medicine; better manage chronic diseases; increase prevention and wellness initiatives; require data transparency; and expand the reach of health information technology. These strategies invite strong partnerships between states and the federal government that I remain committed to pursuing with you. Unfortunately, proposals like S. 1955, are counterintuitive to the notion of forging such partnerships and I ask that you reject the bill.

Sincerely,

CHRISTINE O. GREGOIRE,
Governor.

WASHINGTON STATE
MEDICAL ASSOCIATION,
April 25, 2006.

Hon. PATTY MURRAY,
U.S. Senate, Washington, DC.

DEAR SENATOR MURRAY: On behalf of the 9,000 members of the Washington State Medical Association, WSMA, I am writing to ask that you vote no on S. 1955—Association Health Plans, AHPs, when the bill comes to a vote in the U.S. Senate.

The WSMA is very concerned about the negative effect of this legislation on our State's citizens, purchasers, providers and health plans.

This legislation will have a severe impact on all the consumer health gains that have been made in Washington State over the past decade.

S. 1955 will:

Undermine Washington State's many gains in advancing health care quality;

Pull people from existing insurance coverage rather than attract the uninsured;

Lead to higher costs for consumers;

Strike down Washington's Mental Health Parity law, which took eight years of work to be enacted;

Eliminate other mandated benefits that help consumers such as mammography services; and,

Leave Washington's citizens at risk for unpaid medical bills in the event of an AHP insolvency

The Washington State Medical Association works hard every day to insure that Washington's citizens have access to the finest medical care in the country. This legislation will test our ability to continue in this endeavor.

For more information, please do not hesitate to contact Len Eddinger in our Olympia office.

Very Truly yours,

PETER J. DUNBAR, MD,
President.

The PRESIDING OFFICER (Mr. SMITH). The Senator from Kansas.

Mr. BROWNBACK. Mr. President, I rise to address some issues my colleagues have raised. I am appreciative of the debate and the chance to talk about health care. It is a critically important topic. It is one that we have to talk a lot more about, how we can provide as much health care as possible to everybody at the lowest price that we

can get it and get more people insured. That is at the root of what we are trying to get done with the proposal of Senator ENZI and others to get more health insurance, better coverage to more people across the United States. That is a worthy goal, something we need to do. We have far too many people uninsured. We need more people insured. That is central to us. It is central to the hospital and the provider community that we have people who are insured. Because of those who are not insured and then can't pay the price of their health care, that is spread across to other people, which is what we do today. That is what we need to do, but it would be better if we could get more people insured and have a direct system of payment.

Others have said that what we need to be talking about is different than this, rather than expanding health insurance coverage. I respect that. Some of my colleagues have raised the stem cell issue. I want to address the concerns my colleagues have raised on stem cells. I want to report to my colleagues what a tremendous positive story we have to tell about stem cells, an exciting story of people receiving treatments, living longer and healthier lives because of stem cell treatments. These are not the controversial ones. This does not involve the destruction of a young human in the embryonic stage. This involves the use of adult stem cells, which the Presiding Officer and others, everybody in this room has in their body, adult stem cells. It also involves cord blood stem cells. These are the stem cells that are in the umbilical cord between the mother and child, while the mother is carrying the child.

I want to show two charts to start off. I think it is best if we make this a personal debate. I challenge my colleagues who have challenged me about this topic to come forward with pictures of individuals who are being treated with embryonic stem cells. I would like to see the people who are being treated with embryonic stem cells. We have put nearly half a billion dollars of research money into embryonic stem cell research. We have known about embryonic stem cells for 20 years. I don't know of the people being treated by embryonic stem cells.

I can show people who are being treated with adult stem cells or cord blood. This is Erik Haines. He is 13 years old. He was diagnosed with Krabbes disease, the first patient to receive cord blood for this rare, inherited metabolic disease. The date of transplant was 1994. He is alive today. He would be dead without this having taken place.

Let me show you a picture of Keone Penn. I had him in to testify before a Commerce Committee hearing a couple years ago. He has sickle cell anemia. The date of transplant was December 11, 1998. He had been very sick. He wasn't expected to live. As a matter of fact, it says in a statement that he made: If it wasn't for cord blood, I would probably be dead by now. It is a good thing I found a match. It saved my life.

We have now many more people being treated for sickle cell, a whole host of diseases. As a matter of fact, I want to read off a few of these. These are human clinical trials, real people getting real treatments, living longer lives, if not being cured, by the use of adult stem cells and cord blood stem cells in 69 different disease areas.

My colleagues have heard this debate for a period of years. We have been debating stem cells for a number of years. We have been debating the controversial area of embryonic stem cells, which the Federal Government funds, which State governments fund, which private industry and the private sector is fully free to fund completely, every bit of the way that they want to do that. They can. They have been. And we have no human treatments from embryonic stem cells to date. We don't have any. They are funded globally. There is no prohibition against embryonic stem cell research in the United States.

My colleagues seek more than the nearly $500 billion that we have put into embryonic stem cell research, an area that has not produced any human treatments to date. I want to be clear that that is what we are talking about. When we started this debate, my colleagues pushing embryonic stem cells, who in their hearts absolutely believe they are doing the right thing and this will lead to cures, listed cancer, sickle cell anemia, Lou Gehrig's disease. We are going to deal with all of these things. With the promise of embryonic stem cells, we will cure these things. That is what they said on their side when we started this debate 6 years ago. Six years later—I could be off a year or 2—where are the cures? I say we have them. They are in adult and cord blood stem cells.

I ask unanimous consent to print in the RECORD at the end of my statement a sheet of human clinical applications using adult stem cells.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. BROWNBACK. I want to read a few of the 69 from this document: Sickle cell anemia, aplastic anemia, chronic Epstein-Barr infection, lupus, Crohn's disease, rheumatoid arthritis, juvenile arthritis, multiple sclerosis, brain tumors, different cancers, lymphoma, non-Hodgkins lymphoma, a number of solid tumors, cardiovascular. This is an exciting area that is taking place where we now have people with acute heart damage, chronic coronary artery disease being treated with adult stem cells. Primarily, this has been an adult stem cell treatment where they harvest stem cells out of their own body and inject them right back into the damaged heart tissue.

Now we are seeing people who couldn't walk up a flight of steps going up eight flights, having hard tissue being regenerated with the use of their own adult stem cells. There is no rejection problem. This is their own cells. They take these adult stem cells from your body, which are repair cells, grow them outside of the body, put them back into the damaged heart tissue area, and now instead of congestive heart failure, without any ability to get enough blood throughout the body, the heart is pumping harder and better. It is actually working. They are regenerating the heart in these people. This is actually taking place in human clinical trials today. It is a beautiful issue.

The list goes on: chronic liver failure, Parkinson's disease. I had a gentleman in to testify who had taken stem cells out of a part of his body, grew them, put them in the left part of the brain. The right side of the body started functioning without Parkinson's disease. Later it came back, after several years, but he had several years free and was starting to learn how better this can work with Parkinson's disease.

Again, continuing from the list: spinal cord injury, stroke damage, limb gangrene, skull bone repair. We have recently had advances. For example, they took the stem cells out of a person's body. They had a form around which the bladder could be grown, outside a new bladder could be grown. They took the stem cells, put them around this form, and actually grew a bladder out of a person's own stem cells. These are marvelous, miraculous things that are taking place in 69 different areas of human clinical trials, adult and cord blood. I ask my colleagues from the other side, the ones who promised all of the cures from embryonic stem cells, as this debate moves forward, we will bring out statements that people made 5, 6 years ago about the cures that would come from embryonic stem cells. The cures have come from these noncontroversial areas. This is where we ought to be funding. This is what we ought to be doing. This is where we are getting treatments.

I ask my colleagues from the other side, where are the treatments with embryonic stem cells? Colleagues on the other side, for whom I have great respect and I know in their hearts are doing what they believe is the right thing to do, asked about reputable scientists opposed to embryonic stem cells. I ask unanimous consent to print in the RECORD this letter at the conclusion of my statement.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 2.)

Mr. BROWNBACK. It is dated October 27, 2004. It is to Senator John F. Kerry, running for President at the time, signed by 57 scientists who have a real problem with embryonic stem cell research.

They say in this letter:

As professionals trained in the life sciences we are alarmed at these statements.

They are referring to what Senator KERRY was saying, that this would be a

centerpiece issue for him in moving forward with science. This is in 2004.

First, your statement misrepresents science. In itself, science is not a policy or a political program.

Second, it is no mere ''ideology'' to be concerned about the possible misuse of humans in scientific research.

Here we come to the real rub of the issue on embryonic stem cell research. Is the embryo human life or isn't it? It is one or the other. It is either a human life or it isn't. It is alive. It is human in its genetic form. Is it a human life or not? If it is not a human life, do with it as you choose. If it is a human life, it deserves protection and respect. We do it for everybody in this room, no matter what your State is, your physical condition. Why wouldn't we do it while you are in the womb?

I have a letter signed by 57 scientists with a real problem with embryonic stem cell research. My colleague asked me to produce scientists who are opposed to embryonic stem cell research. Here they are.

I finally say to my colleagues on this topic, the promises they have made about embryonic stem cell research have not been realized to date, and reputable scientists question whether they will ever be realized. We are half a billion dollars later after investment from the Federal Government on embryonic stem cell research, animal and human. Now you are seeing—this is just the Federal Government, not about the private sector or other governments around the world. I will read to you what other scientists who support embryonic stem cell research are saying about the prospects of embryonic stem cell research. A British stem cell research expert, named Winston, warned colleagues that the political hype in support of human embryonic stem cells needs to be reined in. This is dated June 20, 2005, where he says this:

One of the problems is that in order to persuade the public that we must do this work, we often go rather too far in promising what we might achieve. This is a real issue for the scientists. I am not entirely convinced that embryonic stem cells will, in my lifetime, and possibly anybody's lifetime, for that matter, be holding quite the promise that we desperately hope they will.

Let's look at another researcher talking in this field. I want to get testimony in here from Jamie Thompson, the first scientist to grow human embryonic stem cells. This is the question posed to him:

People who use nuclear transfer generally say that the technique is optimized for producing stem cells rather than making babies. They would not want to equate this with the process that produces embryos that were fit for implantation, and they argue that they are used in the reproductive process differently.

I am talking about the use of embryonic stem cell research in a cloning procedure, where you create a clone, take the embryonic stem cells from the clone.

This is what Professor Thompson says:

So you are trying to define it away and it doesn't work. If you create an embryo by nuclear transfer and you give it to somebody, you didn't know where it came from, there would be no test you could do on that embryo to say where it came from. It is what it is. It is an embryo. It is a young human life. It's true that they have much lower probability of giving rise to a child, but by any reasonable definition, at least at some frequency, you are creating an embryo. If you are trying to define it away, you are being disingenuous.

My colleagues started to raise the issue that if you create an embryo by process of cloning, it is not really a young human life. But if you create an embryo that is a sheep, like Dolly, and grow it up to be Dolly the sheep, is Dolly not a sheep? Would that be the contention? That is simply not the case when they are creating a cloned individual or cloned human being, and that goes into the next step in this debate, to discuss human cloning. The other side calls it somatic nuclear cell transfer—the same process that created Dolly.

My point is that that is the next step on this continuum. We are talking about embryonic stem cell research funding and the lack of production taking place there for human treatment. The next step is that we need to clone and then we need to clone the individual and not harvest it in a day or two, but we need to grow the fetus out several weeks so we have sort of fetal farming, which is a ghastly thing to even consider. Yet it is being talked about in some research circles.

I conclude with the statement that if we want to be successful in this area and treat people, which I believe is the measure that we should go by—the treatment of individuals—our best bet, if my colleagues want human treatments to take place, they want to cure people, if that is what their effort is, let's fund what is working, which is adult cord blood. Let's move off of this politicized debate which is about the definition of young human life. Let's move off this debate and do something that is curing people. And we can.

That is the way we ought to go in this debate. We ought to also pass the Enzi proposal that gets more people health insurance, which is where we should focus this debate now because that is what we are talking about, rather than a politicized issue of embryonic stem cell research, which has not worked and is not working.

I yield the floor.

EXHIBIT 1

ADULT & NON-EMBRYONIC STEM CELL RESEARCH

ADVANCES & UPDATES FOR APRIL 2006

HIGHLIGHT OF THE MONTH—STEM CELL HOPE FOR LIVER PATIENTS

British doctors reported treatment of 5 patients with liver failure with the patients' own adult stem cells. Four of the 5 patients showed improvement, and 2 patients regained near normal liver function. The authors noted: ''Liver transplantation is the only current therapeutic modality for liver failure but it is available to only a small proportion of patients due to the shortage of organ donors. Adult stem cell therapy could solve the problem of degenerative disorders, including liver disease, in which organ transplantation is inappropriate or there is a shortage of organ donors.''—Stem Cells Express, Mar. 30, 2006

ADVANCES IN HUMAN TREATMENTS USING ADULT STEM CELLS—

Buerger's Disease: Scientists in Korea using adult stem cell treatments showed significant improvement in the limbs of patients with Buergers disease, where blood vessels are blocked and inflamed, eventually leading to tissue destruction and gangrene in the limb. Out of 27 patients there was a 79% positive response rate and improvement in the limbs, including the healing of previously non-healing ulcers.—Stem Cells Express, Jan. 26, 2006

Bladder Disease: Doctors at Wake Forest constructed new bladders for 7 patients with bladder disease, using the patients' own progenitor cells grown on an artificial framework in the laboratory. When implanted back into the patients, the tissue-engineered bladders appeared to function normally and improved the patients' conditions. ''This suggests that tissue engineering may one day be a solution to the shortage of donor organs in this country for those needing transplants,'' said Dr. Anthony Atala, the lead researcher.—The Lancet, Apr. 4, 2006; reported by the AP, Apr. 4, 2006

Lupus: Adult Stem Cell Transplant Offers Promise for Severe Lupus—Dr. Richard Burt of Northwestern Memorial Hospital is pioneering new research that uses a patient's own adult stem cells to treat extremely severe cases of lupus and other autoimmune diseases such as multiple sclerosis and rheumatoid arthritis. In a recent study of 50 patients with lupus, the treatment with the patients' adult stem cells resulted in stabilization of the disease or even improvement of previous organ damage, and greatly increased survival of patients. ''We bring the patient in, and we give them chemo to destroy their immune system,'' Dr. Burt said. ''And then right after the chemotherapy, we infuse the stems cells to make a brand-new immune system.''—ABC News, Apr. 11, 2006; Journal of the American Medical Assn, Feb. 1, 2006

Cancer: Bush policy may help cure cancer—''Unlike embryonic stem cells . . . cancer stem cells are mutated forms of adult stem cells. . . . Interest in the [adult stem cell] field is growing rapidly, thanks in part, paradoxically, to President George W. Bush's restrictions on embryonic-stem-cell research. Some of the federal funds that might otherwise have gone to embryonic stem cells could be finding their way into cancer [adult]-stem-cell studies.''—Time: Stem Cells that Kill, Apr. 17, 2006

Heart: Adult stem cells may inhibit remodeling and make the heart pump better and more efficiently.—Researchers in Pittsburgh have shown that adding a patient's adult stem cells along with bypass surgery can give significant improvement for those with chronic heart failure. Ten patients treated with their own bone marrow adult stem cells improved well beyond patients who had only standard bypass surgery. In addition, scientists in Arkansas and Boston administered the protein G-CSF to advanced heart failure patients, to activate the patients' bone marrow adult stem cells, and found significant heart improvement 9 months after the treatment.—Journal of Thoracic and Cardiovascular Surgery, Dec., 2005; American Journal of Cardiology, Mar., 2006

Stroke: Mobilizing adult stem cells helps stroke patients—Researchers in Taiwan have shown that mobilizing a stroke patient's bone marrow adult stem cells can improve

recovery. Seven stroke patients were given injections of a protein—G-CSF—that encourages bone marrow stem cells to leave the marrow and enter the bloodstream. From there, they home in on damaged brain tissue and stimulate repair. The 7 patients showed significantly greater improvement after stroke than patients receiving standard care.—Canadian Medical Association Journal Mar. 3, 2006

69 CURRENT HUMAN CLINICAL APPLICATIONS USING ADULT STEM CELLS

ANEMIAS & OTHER BLOOD CONDITIONS

Sickle cell anemia, Sideroblastic anemia, Aplastic anemia, Red cell aplasia (failure of red blood cell development), Amegakaryocytic thrombocytopenia, Thalassemia (genetic [inherited] disorders all of which involve underproduction of hemoglobin), Primary amyloidosis (A disorder of plasma cells), Diamond blackfan anemia, Fanconi's anemia, Chronic Epstein-Barr infection (similar to Mono).

AUTO-IMMUNE DISEASES

Systemic lupus (auto-immune condition that can affect skin, heart, lungs, kidneys, joints, and nervous system), Sjogren's syndrome (autoimmune disease w/symptoms similar to arthritis), Myasthenia (An autoimmune neuromuscular disorder), Autoimmune cytopenia, Scleromyxedema (skin condition), Scleroderma (skin disorder), Crohn's disease (chronic inflammatory disease of the intestines), Behcet's disease, Rheumatoid arthritis, Juvenile arthritis, Multiple sclerosis, Polychondritis (chronic disorder of the cartilage) Systemic vasculitis (inflammation of the blood vessels), Alopecia universalis, Buerger's disease (limb vessel constriction, inflammation).

CANCER

Brain tumors—medulloblastoma and glioma, Retinoblastoma (cancer), Ovarian cancer, Skin cancer: Merkel cell carcinoma, Testicular cancer, Lymphoma, Non-Hodgkin's lymphoma, Hodgkin's lymphoma, Acute lymphoblastic leukemia, Acute myelogenous leukemia, Chronic myelogenous leukemia, Juvenile myelomonocytic leukemia, Cancer of the lymph nodes: Angioimmunoblastic lymphadenopathy, Multiple myeloma (cancer affecting white blood cells of the immune system), Myelodysplasia (bone marrow disorder), Breast cancer, Neuroblastoma (childhood cancer of the nervous system), Renal cell carcinoma (cancer of the kidney), Soft tissue sarcoma (malignant tumor that begins in the muscle, fat, fibrous tissue, blood vessels), Various solid tumors, Waldenstrom's macroglobulinemia (type of lymphoma), Hemophagocytic lymphohistiocyctosis, POEMS syndrome (osteosclerotic myeloma), Myelofibrosis.

CARDIOVASCULAR

Acute Heart damage, Chronic coronary artery disease.

IMMUNODEFICIENCIES

Severe combined immunodeficiency syndrome, X-linked lymphoproliferative syndrome, X-linked hyper immunoglobulin M syndrome.

LIVER DISEASE

Chronic liver failure.

NEURAL DEGENERATIVE DISEASES & INJURIES

Parkinson's disease, Spinal cord injury, Stroke damage.

OCULAR

Corneal regeneration.

WOUNDS & INJURIES

Limb gangrene, Surface wound healing, Jawbone replacement, Skull bone repair.

OTHER METABOLIC DISORDERS

Sandhoff disease (hereditary genetic disorder), Hurler's syndrome (hereditary genetic disorder), Osteogenesis imperfecta (bone/cartilage disorder), Krabbe Leukodystrophy (hereditary genetic disorder), Osteopetrosis (genetic bone disorder), Cerebral X-linked adrenoleukodystrophy.

EXHIBIT 2

OCTOBER 27, 2004.

Senator JOHN F. KERRY,
John Kerry for President,
Washington, DC.

DEAR SENATOR KERRY: Recently you have made the promotion of embryonic stem cell research, including the cloning of human embryos for research purposes, into a centerpiece of your campaign. You have said you will make such research a ''top priority'' for government, academia and medicine (Los Angeles Times, 10/17/04). You have even equated support for this research with respect for ''science,'' and said that science must be freed from ''ideology'' to produce miracle cures for numerous diseases.

As professionals trained in the life sciences we are alarmed at these statements.

First, your statements misrepresent science. In itself, science is not a policy or a political program. Science is a systematic method for developing and testing hypotheses about the physical world. It does not ''promise'' miracle cures based on scanty evidence. When scientists make such assertions, they are acting as individuals, out of their own personal faith and hopes, not as the voice of ''science''. If such scientists allow their individual faith in the future of embryonic stem cell research to be interpreted as a reliable prediction of the outcome of this research, they are acting irresponsibly.

Second, it is no mere ''ideology'' to be concerned about the possible misuse of humans in scientific research. Federal bioethics advisory groups, serving under both Democratic and Republican presidents, have affirmed that the human embryo is a developing form of human life that deserves respect. Indeed you have said that human life begins at conception, that fertilization produces a ''human being.'' To equate concern for these beings with mere ''ideology'' is to dismiss the entire history of efforts to protect human subjects from research abuse.

Third, the statements you have made regarding the purported medical applications of embryonic stem cells reach far beyond any credible evidence, ignoring the limited state of our knowledge about embryonic stem cells and the advances in other areas of research that may render use of these cells unnecessary for many applications. To make such exaggerated claims, at this stage of our knowledge, is not only scientifically irresponsible—it is deceptive and cruel to millions of patients and their families who hope desperately for cures and have come to rely on the scientific community for accurate information.

What does science tell us about embryonic stem cells? The facts can be summed up as follows:

At present these cells can be obtained only by destroying live human embryos at the blastocyst (4–7 days old) stage. They proliferate rapidly and are extremely versatile, ultimately capable (in an embryonic environment) of forming any kind of cell found in the developed human body. Yet there is scant scientific evidence that embryonic stem cells will form normal tissues in a culture dish, and the very versatility of these cells is now known to be a disadvantage as well—embryonic stem cells are difficult to develop into a stable cell line, spontaneously accumulate genetic abnormalities in culture, and are prone to uncontrollable growth and tumor formation when placed in animals.

Almost 25 years of research using mouse embryonic stem cells have produced limited indications of clinical benefit in some animals, as well as indications of serious and potentially lethal side-effects. Based on this evidence, claims of a safe and reliable treatment for any disease in humans are premature at best.

Embryonic stem cells obtained by destroying cloned human embryos pose an additional ethical issue—that of creating human lives solely to destroy them for research—and may pose added practical problems as well. The cloning process is now known to produce many problems of chaotic gene expression, and this may affect the usefulness and safety of these cells. Nor is it proven that cloning will prevent all rejection of embryonic stem cells, as even genetically matched stem cells from cloning are sometimes rejected by animal hosts. Some animal trials in research cloning have required placing cloned embryos in a womb and developing them to the fetal stage, then destroying them for their more developed tissues, to provide clinical benefit—surely an approach that poses horrific ethical issues if applied to humans.

Non-embryonic stem cells have also received increasing scientific attention. Here the trajectory has been very different from that of embryonic stem cells: Instead of developing these cells and deducing that they may someday have a clinical use, researchers have discovered them producing undoubted clinical benefits and then sought to better understand how and why they work so they can be put to more uses. Bone marrow transplants were benefiting patients with various forms of cancer for many years before it was understood that the active ingredients in these transplants are stem cells. Non-embryonic stem cells have been discovered in many unexpected tissues—in blood, nerve, fat, skin, muscle, umbilical cord blood, placenta, even dental pulp—and dozens of studies indicate that they are far more versatile than once thought. Use of these cells poses no serious ethical problem, and may avoid all problems of tissue rejection if stem cells can be obtained from a patient for use in that same patient. Clinical use of non-embryonic stem cells has grown greatly in recent years. In contrast to embryonic stem cells, adult stem cells are in established or experimental use to treat human patients with several dozen conditions, according to the National Institutes of Health and the National Marrow Donor Program (Cong. Record, September 9, 2004, pages H6956–7). They have been or are being assessed in human trials for treatment of spinal cord injury, Parkinson's disease, stroke, cardiac damage, multiple sclerosis, and so on. The results of these experimental trials will help us better assess the medical prospects for stem cell therapies.

In the case of many conditions, advances are likely to come from sources other than any kind of stem cell. For example, there is a strong scientific consensus that complex diseases such as Alzheimer's are unlikely to be treated by any stem cell therapy. When asked recently why so many people nonetheless believe that embryonic stem cells will provide a cure for Alzheimer's disease, NIH stem cell expert Ron McKay commented that ''people need a fairy tale'' (Washington Post, June 10, 2004, page A3). Similarly, autoimmune diseases like juvenile diabetes, lupus and MS are unlikely to benefit from simple addition of new cells unless the underlying problem—a faulty immune system that attacks the body's own cells as though they were foreign invaders—is corrected.

In short, embryonic stem cells pose one especially controversial avenue toward understanding and (perhaps) someday treating various degenerative diseases. Based on the available evidence, no one can predict with

certainty whether they will ever produce clinical benefits—much less whether they will produce benefits unobtainable by other, less ethically problematic means.

Therefore, to turn this one approach into a political campaign—even more, to declare that it will be a ''top priority'' or receive any particular amount of federal funding, regardless of future evidence or the usual scientific peer review process—is, in our view, irresponsible. It is, in fact, a subordination of science to ideology.

Because politicians, biotechnology interests and even some scientists have publicly exaggerated the ''promise'' of embryonic stem cells, public perceptions of this avenue have become skewed and unrealistic. Politicians may hope to benefit from these false hopes to win elections, knowing that the collision of these hopes with reality will come only after they win their races. The scientific and medical professions have no such luxury. When desperate patients discover that they have been subjected to a salesman's pitch rather than an objective and candid assessment of possibilities, we have reason to fear a public backlash against the credibility of our professions. We urge you not to exacerbate this problem now by repeating false promises that exploit patients' hopes for political gain.

Signed by 57 doctors.

The PRESIDING OFFICER (Mr. CORNYN). The Senator from Minnesota is recognized.

Mr. DAYTON. Mr. President, I ask unanimous consent to speak for 15 minutes as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

REPORT ON HURRICANE KATRINA

Mr. DAYTON. Mr. President, last week the Senate Committee on Homeland Security and Governmental Affairs, of which I am a member, approved its report titled ''Hurricane Katrina, A Nation Still Unprepared.'' The committee's distinguished chairman set today as the deadline for additional views.

I reluctantly voted not to approve that draft of the report last week because it is seriously incomplete. While it is still lacking all of the information, documents, and testimony which President Bush and his subordinates denied the committee, last March 15 the ranking member asked the chairman to subpoena witnesses and documents that have been withheld by the White House. Regrettably, she declined to do so.

Earlier this year, on January 12, the chairman and ranking member wrote the White House Chief of Staff, Mr. Andrew Card, regarding the information they had previously requested. Their letter stated, in part:

This practice (of withholding information) must cease.

It continued:

We are willing to discuss claims of executive privilege asserted by the White House, either directly or through a Federal agency. But we will not stand for blanket instructions to refuse answering any questions concerning any communications with the EOP [Executive Office of the President].

Their insistence that either administration officials comply with this oversight committee's rightful demands or the President invoke his executive privilege not to do so was entirely appropriate. Unfortunately, when Mr. Card and his subordinates still refused to comply, the chairman denied the ranking member's request to issue subpoenas.

Regrettably, at its markup of the draft report, the Senate committee failed to support my motion to subpoena those documents and witnesses, which were being withheld by the White House without claim to executive privilege, and which were being wrongfully denied by executive agencies.

The administration's refusal to comply and cooperate with this investigation is deplorable, as is the Homeland Security Committee's failure to back the chairman and ranking member's proper insistence that the White House do so. That committee is charged by the full Senate with the responsibility to oversee the agencies, programs, and activities that are related to homeland security. The committee was expressly directed by the Senate majority leader to examine the Bush administration's failure to respond quickly or effectively to the disasters caused by Hurricane Katrina. This investigation is not complete without all of the information requested from the administration. Furthermore, the report's findings and conclusions can hardly be considered reliable if the White House has decided what information to provide and what information to withhold from the committee.

This unfortunate acquiescence confirms the judgment of the Senate Democratic leader that an independent bipartisan commission was necessary to ensure complete and unbiased investigation into the failed Federal, State, and local responses to Hurricane Katrina. His request has been repeatedly denied by the majority, with the assurance that the Senate committee would fulfill those responsibilities. Tragically and reprehensibly, it has failed to do so. Thus, the committee failed the Senate's constitutional obligations to be an independent, coequal branch of Government from the executive. It also failed the long-suffering victims of Hurricane Katrina, who deserve to know why their governments failed them, and all of the American people, who depend upon their elected representatives to protect their lives and their interests, without regard to partisan political considerations. That partisanship includes unjustified protection of an administration of the same political party, as much as undue criticism of one from another party.

That partisan protectionism is especially unwarranted given widespread agreement about the urgent need to understand the failures during and after Hurricane Katrina and to remedy them before another large-scale disaster, God forbid, should occur.

Now, 8 months after the hurricane, the lack of progress in cleanup, repair, and reconstruction in devastated areas provides further evidence of the Federal Government's continuing failure to respond efficiently or effectively. There is no time in which the helping hand of Government is more urgently needed and more surely deserved than during and after a disaster. Victims are damaged or devastated physically, emotionally, and financially.

Local officials and their public services are overwhelmed, if not destroyed. They need a Federal emergency response organization comprised of experienced, dedicated professionals, who have the resources necessary to alleviate short-term suffering and commence long-term recovery, and also have the authority to expeditiously commit those resources.

What the failed Federal response to Hurricane Katrina showed is the utter ineptitude of the Federal Emergency Management Agency, known as FEMA. Even worse, FEMA's indifference and incompetence in the aftermath of Katrina was not an isolated instance. In my direct experience with FEMA's disaster relief responses in Minnesota, the agency is too often a major obstruction to recovery projects rather than a principal ally.

Thus, I agree with the report's recommendation to create a new, comprehensive emergency management organization, to prepare for and respond to all disasters and catastrophes. I remain openminded about whether this new entity should remain within the Department of Homeland Security, as this recommendation intends, or be established as a separate Federal agency. The challenge for the committee, for all of Congress, and for the administration will be to actually recreate an existing Federal agency which has become dysfunctional and nonfunctional. Merely ''reforming'' FEMA by rearranging some boxes and lines in its organizational chart, revising it, and giving its head a new title, will be woefully inadequate. The new organization must be more streamlined, centralized, and compact than its predecessor. It must be less bureaucratic, less consumed with regulatory minutiae, and less resistant to local recovery initiatives. It must spend less time creating complex plans and cumbersome procedures, and more time in training and perfecting action responses to emergency situations.

History shows that ''if a student does not learn the lesson, the teacher reappears.'' This report describes some of the most important lessons from the failed response to Hurricane Katrina. The committee's and this Congress's subsequent actions to correct these serious deficiencies before the next catastrophe will indicate whether those lessons will be learned.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. AKAKA. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. AKAKA. Mr. President, I ask unanimous consent that I be allowed to speak for 10 minutes as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

NATIVE HAWAIIAN GOVERNMENT REORGANIZATION ACT OF 2005

Mr. AKAKA. Mr. President, I rise today to talk about bipartisan legislation that is of critical importance to the people of Hawaii. S. 147, the Native Hawaiian Government Reorganization Act of 2005, would extend the Federal policy of self-governance and self-determination to Hawaii's indigenous peoples, Native Hawaiians, by authorizing a process for the reorganization of a Native Hawaiian governing entity for the purposes of a government-to-government relationship with the United States.

Together with my senior Senator and the rest of Hawaii's congressional delegation, I first introduced this bill in 1999. The bill passed the House in 2000, but, unfortunately, the Senate adjourned before we could complete consideration of that bill.

Since then, I have introduced a bill every Congress. In every Congress, the committees of jurisdiction—the Senate Committee on Indian Affairs and the House Committee on Resources—have favorably reported the bill and its companion measure.

I thank the majority leader, the senior Senator from Tennessee, who is working to uphold his commitment to bring this bill to the Senate floor for a debate and rollcall vote. I must tell my colleagues that he did try to meet his commitment in September 2005 and did schedule it for the floor. But at that time, Katrina happened, and we took it off the calendar.

I also appreciate the efforts of my colleague from Arizona who opposes the bill on substance, but has worked with me to uphold his promise to allow the bill to come to the floor for debate and rollcall vote.

S. 147 does three things. First, it authorizes the Office of Native Hawaiian Relations in the Department of the Interior. The office is intended to serve as a liaison between Native Hawaiians and the United States. It is not intended to become another Bureau of Indian Affairs, as the current program for Native Hawaiians will remain with the agencies that currently administer those programs.

Second, the bill establishes the Native Hawaiian interagency coordinating group. This is a Federal working group to be composed of representatives from Federal agencies who administer programs and services for Native Hawaiians. There is no statutory requirement for these agencies to work together. This working group can coordinate policies to ensure consistency and prevent unnecessary duplication in Federal policies impacting Native Hawaiians.

Finally, the bill authorizes a process for the reorganization of the Native Hawaiian governing entity. And we ask: Why do we need to organize the entity? It is because the Native Hawaiian Government was overthrown with the assistance of U.S. agents in 1893. Rather than shed the blood of the people, our beloved queen, Queen Lili'uokalani, abdicated her throne after being arrested and imprisoned in her own home.

Following the overthrow, a republic was formed. Any reformation of a native governing entity has been discouraged. Despite this fact, Native Hawaiians have established distinct communities and retained their language, culture, and traditions. They have done so in a way that also allows other cultures to flourish in Hawaii. Now their generosity is being used against them by opponents of this bill who claim that because Native Hawaiians do not have a governing entity, they cannot partake in the Federal policy of self-governance and self-determination that is offered to their native brethren in the United States.

My bill authorizes a process for the reorganization of the Native Hawaiian governing entity for the purposes of a federally recognized government-to-government relationship. There are many checks and balances in this process which has the structure necessary to comply—to comply—with Federal law and still maintains the flexibility for Native Hawaiians to determine the outcome of this process.

Further, my bill includes a negotiations process between the Native Hawaiian governing entity, the State of Hawaii, and the United States to address issues such as lands, natural resources, assets, criminal and civil jurisdiction, and historical grievances. Nothing that is currently within the jurisdiction of another level of government can be conveyed to the Native Hawaiian Government without going through this negotiations process.

I am proud of the fact that this bill respects the rights of Hawaii's indigenous peoples through a process that is consistent with Federal law and it provides the structured process for the people of Hawaii to address the long-standing issues which have plagued both Native Hawaiians and non-Native Hawaiians since the overthrow of the Kingdom of Hawaii.

I want to reiterate to my colleagues that this bill is not race based. This bill is based on the Federal policies toward indigenous peoples. Those who characterize this bill as race based fail to understand the Federal policies toward indigenous peoples. Those who characterize this bill as race based fail to understand the legal and political relationship the United States had with the indigenous peoples and their governments preexisting the United States.

Finally, those who characterize this bill as race based are saying that Native Hawaiians are not native enough. I find this offensive. And I ask that my colleagues join me in my efforts to bring parity to Native Hawaiians by enacting my bill.

This effort will continue from day-to-day here. We will continue to bring forward the history of Hawaii and the reasons why we are trying to enact this bill, not only for the benefit of the indigenous people of Hawaii but for the benefit of the United States as well.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. VOINOVICH. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. THUNE). Without objection, it is so ordered.

MORNING BUSINESS

Mr. VOINOVICH. Mr. President, I ask unanimous consent that there now be a period of morning business with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

VOTE EXPLANATION

Mr. DURBIN. Mr. President, yesterday, the Senate voted on two motions to invoke cloture to proceed to legislation regarding medical malpractice. Due to a mechanical problem with the plane on my flight from Chicago, I was necessarily absent for this debate and the first vote. Had I been present for that vote, I would have voted against the motion to invoke cloture, and I did vote against the second motion.

Since 2003, the last time Congress considered this issue, 34 States have passed malpractice legislation. Four additional States have pending legislation in this year.

AMA counts 21 States as ''crisis'' States. Of those 21 States, 16 States passed legislation in the past 2 years, and two are currently considering bills.

Instead of considering ways to cap pain and suffering damages for injured patients, Congress should be working on other health care priorities.

Neither S. 22 nor S. 23 do anything to address medical errors, the underlying reason for medical malpractice lawsuits.

According to the Institute of Medicine, medical errors have caused more American deaths per year than breast cancer, AIDS and car accidents combined. It is equivalent to a jumbo jet liner crashing every 24 hours for 1 year.

When I sat on the Government Affairs Committee, Dr. Carolyn Clancy, Director of the Agency for Healthcare Research and Quality, testified about patient safety.

She called medical errors ''a national problem of epidemic proportions.'' She went on to say that Congress and HHS need to make sure that health care professionals work in systems that are designed to prevent mistakes and catch problems before they cause harm.

These bills will do nothing to reach that goal.

The most far-reaching study of the extent and cost of medical errors in our hospitals was published in the Journal of the American Medical Association, the authors of the study analyzed 7.45 million records from 994 hospitals in 28 States, a sample representative of about 20 percent of U.S. hospitals.

They concluded that medical injuries in hospitals ''pose a significant threat to patients and incur substantial costs to society'' and ''are a serious epidemic confronting our health care system.''

The study found that injuries in U.S. hospitals in 2000, just 1 year, led to approximately 32,600 deaths, at least 2.4 million extra days of patient hospitalization and additional costs of up to $9.3 billion. These injuries did not include adverse drug reactions or malfunctioning medical devices.

What do these bills do about these medical errors? Nothing.

Instead, these bills place an arbitrary, one-size-fits-all cap on noneconomic damages, forfeiting the right of a jury to decide the appropriate level of compensation for an injured person.

The answer to this problem is not to have Congress deciding what injured patients should receive. America has judges and juries who make those decisions. One hundred Senators do not have all the facts and should not place a blanket cap on all cases.

Proponents of this bill are saying it is a ''new'' medical malpractice proposal because a patient could receive up to $750,000 in pain and suffering as opposed to the $250,000 cap we considered in 2003.

However, the cap is still $250,000 for a doctor, a hospital or other provider. If a patient is injured at three hospitals or by three doctors, he or she could receive a total $750,000, but the cap is still $250,000 per provider.

Ten years ago, Donna Harnett arrived at a hospital in Chicago, IL, in labor with her first child. She waited nearly 5 hours before being admitted. Following an initial examination, her doctor decided that her labor was not progressing quickly enough and prescribed a drug to help induce more contractions.

Later, when Donna's labor still was not progressing, her doctor broke her water and found that it was abnormal. Rather than consider a C-section, Donna's doctor decided to continue administering the drug, in hopes that the labor would progress.

Six hours later, Donna still hadn't delivered, but her son's fetal monitoring system began alarming, indicating that the baby was in serious respiratory distress. The doctor finally decided that it was time to perform an emergency C-section, but it was another hour before Donna was taken into the operating room.

During that time, the doctor failed to administer oxygen or an IV to help the baby breathe. After Martin was born, he remained in the intensive care unit for 3 weeks. Examinations have since revealed that Martin has substantial brain damage and cerebral palsy—a direct result of the doctor's failure to respond to indications of serious oxygen deprivation and deliver in a timely manner.

Donna's doctor told her never to have more children because there was a serious problem with her DNA, which could result in similar mental and physical disabilities in any of her future children.

Donna has since given birth to three perfectly healthy sons. Donna sued the doctor responsible for Martin's delivery and received a settlement, but this doctor is still licensed and practicing medicine in Illinois—despite several other cases that have been filed against him.

Donna is thankful that she has money from a malpractice settlement to help cover the costs associated with Martin's care that are not covered by health insurance—such as the used, wheelchair-accessible van that she purchased for $50,000, and the $100,000 for renovating the new home she purchased to make it accessible for Martin.

If the law we are debating today had been in place when Donna filed her malpractice suit against the doctor who delivered Martin, she doubts that she would have been able to keep him out of an institution, because as someone who sustained permanent injuries as a newborn, Martin would not have been eligible for an economic damage award.

The problem with malpractice premiums is a cyclical insurance problem. We had a crisis during the 1970s and again in the 1980s. Dozens of States have passed tort reform. Yet we find ourselves faced with the same problems. That is because we haven't looked closely at insurance companies.

Property casualty insurers had a record year in 2005.

The property casualty insurance industry made $43 billion in profit last year.

The difference between the cost of the policies offered to doctors and hospitals, and the payouts from lawsuits is enormous. Payouts have remained steady while premiums have skyrocketed.

Wonder where that money is going?

Jeffry Immelt, the CEO of GE, made $19.23 million last year.

Martin Sullivan, CEO of American International Group, made $11 million.

Stephen Lilienthal, CEO of CNA Financial Corporation, made $3.2 million.

A. Derrill Crowe, CEO of ProAssurance, made $1.5 million.

This bill completely ignores the role of insurers in this problem.

Between 1993 and 2003, the annual premiums Americans paid for their health insurance increased by 79 percent and employer contributions to their employee insurance increased by 90 percent.

We need to be looking at the underlying reasons for rising health costs, and these bills do nothing to achieve that goal.

In fact, a new CBO report, published last Friday concluded that ''the estimated effect of implementing a package of previously proposed tort limits is near zero.''

In other words, capping pain and suffering for patients will not bring down health insurance costs.

Proponents of limiting pain and suffering claim frivolous lawsuits are at the root of the problem, but these bills do nothing to cut down on the number of lawsuits. They only punish those who have legitimate cases.

The people whose cases make it to jury verdicts have surmounted many hurdles. Cases without merit are thrown out before they ever reach the jury. Why would we want to limit pain and suffering for those whose cases make it through the system?

Medical malpractice is a complicated and multifaceted problem that requires a variety of solutions.

First, we must improve patient safety. Medicare is starting to embrace something called Pay for Performance that will go a long way toward improving quality.

The idea of Pay for Performance is to pay doctors based on whether they fulfill certain quality standards and use the best treatment methods, rather than simply reimbursing for all services performed.

Under a Medicare pilot program, doctors can qualify for bonuses if they provide services like vaccines and cancer screening, and eliminate unnecessary procedures.

Here is an example of how it can improve quality.

Hackensack University Medical Center in New Jersey signed up for the program. It agreed to report its performance on a variety of measures.

Right away, the hospitals noticed some problem areas. Under clinical guidelines, a patient who has had orthopedic surgery should be taken off IV antibiotics after 24 hours. Longer use of the drugs don't prevent infection, they cost money, and they can lead to greater antibiotic resistance.

Hackensack hospital found that 25 percent of their surgery patients were being kept on IV antibiotics longer than 24 hours. Within one week of the launch of the Pay for Performance program, 94 percent of patients were taken off the drugs on time.

Second, we must improve oversight. We have something called the National Practitioner Data Bank, which was set up to allow licensing boards and employers to check on doctors' records before they are hired so problem doctors could not move from state to state.

This data bank is not working. According to the federal Department of Health and Human Services, nearly 54 percent of all hospitals have never reported a disciplinary action to the data bank.

Federal law requires that hospitals and medical boards be penalized if they don't report to the data bank. But no fine or penalty has ever been levied.

Further, hospitals sometimes agree not to report doctors they are forcing from their staffs to smooth their departure. Also, physicians' names are removed from malpractice settlements to keep them out of the data bank.

The failings of the data bank create problems like the one faced by Gwyneth Vives. Three hours after giving birth to a healthy boy in 2001, Vives, a scientist at Los Alamos National Laboratory in New Mexico, suffered a complication and bled to death.

The OB/GYN who tended to Ms. Vives had a troubled history. She had previously been forced to leave a job at Duke University Medical Center in North Carolina when questions arose about her surgical skills and her complication rate.

According to the New Mexico Medical Board, she lied to get her New Mexico license, saying she had never lost hospital privileges.

After Ms. Vives died, the OB/GYN went to Michigan and got a license.

We must improve the national practitioner database system so the few doctors who are causing medical injuries cannot simply move to another State.

Contrary to popular belief about frivolous lawsuits, 95 percent of people who are injured by a doctor do not sue.

Studies have shown that the most significant reason people sue is because they feel their doctor or hospital did not acknowledge the problem, or apologize. In other words, they are angry.

Based on this data, a program called ''Sorry Works'' has been launched. Under the program, doctors and hospital staff conduct analyses after every patient injury, and if a medical error caused the problem, the doctors and hospital staff apologize, provide solutions to fix the problem, and offer upfront compensation to the patient, family, and their attorney.

This approach helps alleviate anger and actually reduces the chances of litigation and costly defense litigation bills. The program has worked successfully at hospitals such as the University of Michigan Hospital system, Stanford Medical Center, Children's Hospitals and Clinics of Minnesota, and the VA Hospital in Lexington, Kentucky.

I am proud to say that Illinois is the first State to enact a Sorry Works pilot program statewide.

My colleague from Illinois, BARACK OBAMA, has introduced a bill in the U.S. Senate to facilitate federal funding for apology programs.

The insurance industry has a blanket exemption from Federal antitrust laws. Using their exemption, insurers can collude to set rates, resulting in higher premiums than true competition would achieve—and because of this exemption, enforcement officials cannot investigate any such collusion.

There was an article in the Washington Post last Friday about Hank Greenberg, the former chairman of one of the largest malpractice insurers in the country, American Continental Group.

Mr. Greenberg has been sued by New York Attorney General Eliot Spitzer for fraudulent transactions aimed at manipulating the insurer's financial statements and deceiving regulators and investors.

If Congress is serious about controlling rising medical malpractice premiums, we must revoke this blanket exemption created in the McCarran-Ferguson act.

I am a cosponsor of a bill introduced by Senator LEAHY called the Medical Malpractice Insurance Antitrust Act. Our bill modifies the McCarran-Ferguson Act for the most pernicious antitrust offenses: price fixing, bid rigging, and market allocations.

Who could object to a prohibition on insurance carriers' fixing prices or dividing territories for anticompetitive purposes. After all, the rest of our Nation's industries manage either to abide by these laws or pay the consequences.

We need to stop insurers from gouging doctors and hospitals and this bill is a step in the right direction.

LOCAL LAW ENFORCEMENT ENHANCEMENT ACT OF 2005

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. Each Congress, Senator KENNEDY and I introduce hate crimes legislation that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society. Likewise, each Congress I have come to the floor to highlight a separate hate crime that has occurred in our country.

On March 7, 2006, in New York, NY, Victor Lopez and David Andrade were sentenced separately to 8 years in prison for their involvement in a series of beatings that targeted gay men. Lopez and Andrade would pick up gay men, then beat and rob them. According to police, these attacks were motivated by the victims sexual orientation.

I believe that the Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

HONORING OUR ARMED FORCES

STAFF SERGEANT JOSEPH E. PROCTOR

Mr. BAYH. Mr. President, I rise today with a heavy heart and deep sense of gratitude to honor the life of a brave man from Indianapolis. Joseph E. Proctor, 38 years old, was killed on May 2 in a suicide bombing near his observation post in Iraq. Leaving his life and family behind him, Joseph risked everything to fight for the values Americans hold close to our hearts, in a land halfway around the world.

After September 11, many Americans, including Joseph, felt a deep calling to help their country in its time of need. In the wake of the attacks, despite his family's concerns over his safety, Joseph signed up for the Indiana National Guard, where he had served 20 years ago as a young man. After his Guard service in the mid-1980s, he went into the Army on active duty and served in Desert Storm. Joseph re-enlisted in the Guard in 2002, and began work as a refueler in Iraq. His brother Eddie told a local news outlet that Joseph had seen his military service as a way to help out fellow soldiers. He recounted Joseph's selflessness, saying that one of the reasons Joseph went to Iraq was to give other soldiers a break to come home and see their families. At the time of his death, he was supposed to return home in just 2 weeks.

Joseph was killed while serving his country in Operation Iraqi Freedom. He was assigned to the 638th Aviation Support Battalion in Noblesville. This brave soldier leaves behind his wife, Beth, and three children, Joe, 20, Cassandra, 17, and Adam, 11, years old.

Today, I join Joseph's family and friends in mourning his death. While we struggle to bear our sorrow over this loss, we can also take pride in the example he set, bravely fighting to make the world a safer place. It is his courage and strength of character that people will remember when they think of Joseph, a memory that will burn brightly during these continuing days of conflict and grief.

Joseph was known for his dedication to his family and his love of country. Today and always, Joseph will be remembered by family members, friends and fellow Hoosiers as a true American hero and we honor the sacrifice he made while dutifully serving his country.

As I search for words to do justice in honoring Joseph's sacrifice, I am reminded of President Lincoln's remarks as he addressed the families of the fallen soldiers in Gettysburg: ''We cannot dedicate, we cannot consecrate, we cannot hallow this ground. The brave men, living and dead, who struggled here, have consecrated it, far above our poor power to add or detract. The world will little note nor long remember what we say here, but it can never forget what they did here.'' This statement is just as true today as it was nearly 150 years ago, as I am certain that the impact of Joseph's actions will live on far longer that any record of these words.

It is my sad duty to enter the name of Joseph Proctor in the official record

of the U.S. Senate for his service to this country and for his profound commitment to freedom, democracy and peace. When I think about this just cause in which we are engaged, and the unfortunate pain that comes with the loss of our heroes, I hope that families like Joseph's can find comfort in the words of the prophet Isaiah who said, ''He will swallow up death in victory; and the Lord God will wipe away tears from off all faces.''

May God grant strength and peace to those who mourn, and may God be with all of you, as I know He is with Joseph.

HONORING CORPORAL ERIC LUEKEN

Mr. President, I rise today with a heavy heart and deep sense of gratitude to honor the life of a brave young Marine from Southern Indiana. Eric Lueken, 23 years old, died on April 22 in combat operations in the Anbar province of Iraq. With his entire life before him, Eric risked everything to fight for the values Americans hold close to our hearts, in a land halfway around the world.

A 2001 graduate of Northeast Dubois High School, Eric joined the Marine Corps in October 2003 to challenge himself and see the world. He previously served in Afghanistan for 8 months, before heading out to Iraq in March. He was a decorated war hero, who was awarded with a Purple Heart, two Combat Action Ribbons, a National Defense Service Medal, a Sea Service Deployment Ribbon, Iraq and Afghanistan Service Medals and the Global War on Terror Service Medal. A Marine who took his work seriously, Eric had planned to marry his girlfriend Ericka Merkel upon his return from Iraq. She told a local paper, ''He always put other people before him.'' I stand here today to express my gratitude for Eric's sacrifice and that of his family and loved ones.

Eric was killed while serving his country in Operation Iraqi Freedom. He was assigned to the 3rd Battalion, 3rd Marine Regiment, 3rd Marine Division, III Marine Expeditionary Force based at Kaneohe Bay, Hawaii. This brave young soldier leaves behind his parents Glenn ''Jake'' and Melinda Lueken, and his brother Brent.

Today, I join Eric's family and friends in mourning his death. While we struggle to bear our sorrow over this loss, we can also take pride in the example he set, bravely fighting to make the world a safer place. It is his courage and strength of character that people will remember when they think of Eric, a memory that will burn brightly during these continuing days of conflict and grief.

Eric was known for his dedication to his family and his love of country. Today and always, Eric will be remembered by family members, friends and fellow Hoosiers as a true American hero and we honor the sacrifice he made while dutifully serving his country.

As I search for words to do justice in honoring Eric's sacrifice, I am reminded of President Lincoln's remarks as he addressed the families of the fallen soldiers in Gettysburg: ''We cannot dedicate, we cannot consecrate, we cannot hallow this ground. The brave men, living and dead, who struggled here, have consecrated it, far above our poor power to add or detract. The world will little note nor long remember what we say here, but it can never forget what they did here.'' This statement is just as true today as it was nearly 150 years ago, as I am certain that the impact of Eric's actions will live on far longer that any record of these words.

It is my sad duty to enter the name of Eric Lueken in the official record of the U.S. Senate for his service to this country and for his profound commitment to freedom, democracy and peace. When I think about this just cause in which we are engaged, and the unfortunate pain that comes with the loss of our heroes, I hope that families like Eric's can find comfort in the words of the prophet Isaiah who said, ''He will swallow up death in victory; and the Lord God will wipe away tears from off all faces.''

May God grant strength and peace to those who mourn, and may God be with all of you, as I know He is with Eric.

HONORING STAFF SERGEANT ERIC A. MC INTOSH

Mr. President, I rise today with a heavy heart and deep sense of gratitude to honor the life of a brave young man from Indianapolis. Eric McIntosh, 29 years old, was one of three Marines killed on April 2 during combat operations in the Anbar province of Iraq. With his entire life before him, Eric risked everything to fight for the values Americans hold close to our hearts, in a land halfway around the world.

A former Roncalli High School student, Eric had been in the Marines for 10 years and was on his second tour in Iraq when he was killed. Although he graduated high school unsure of what he wanted to do with his life, he found purpose during his time as a Marine. After completing his second tour, he hoped to become a recruiter for the military. Despite having battled asthma as a child, Eric was an avid athlete and an enthusiastic surfer. His brother Richard, who served in the Army during the Gulf War, recalled his pride in Eric and Eric's passion for his job. ''He loved the Marines. He loved his job,'' said Richard. ''He was a way better soldier than I was.''

Eric was killed while serving his country in Operation Iraqi Freedom. He was a member of the 3rd Battalion, 8th Marine Regiment, 2nd Marine Division, II Marine Expeditionary Force. This brave young soldier leaves behind his mother Betty, his brother Richard, his sister Lisa Schoenly; and his wife Cynthia.

Today, I join Eric's family and friends in mourning his death. While we struggle to bear our sorrow over this loss, we can also take pride in the example he set, bravely fighting to make the world a safer place. It is his courage and strength of character that people will remember when they think of Eric, a memory that will burn brightly during these continuing days of conflict and grief.

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May God grant strength and peace to those who mourn, and may God be with all of you, as I know He is with Eric.

COSPONSORSHIP OF S. 722

Mr. BURNS. Mr. President, I rise today to express my support for legislation introduced in the Senate which has a significant impact on more than 800 small businesses in Montana and hundreds of thousands more around the country. S. 722 would reduce the tax burden on every barrel of beer, which currently stands at $18. Prior to 1991, this tax was only half of the cost today.

This tax was originally enacted as a means to pay for the U.S. Civil War. The lesson is that there is no such thing as a short-term tax. The tax on beer, which accounts for 44 percent of a bottle of beer and a whopping 80 percent cost of a six-pack, has been steadily increasing since 1991.

The taxation of beer falls unfairly on Montanans who can least afford to pay it. A report by Citizens for Tax Justice indicates that people whose family's income is in the top 20 percent pay five times less in excise beer tax than those whose family is in the bottom 20 percent.

The Tax Code was intended to raise revenue for the Federal Government. It should not be used to influence behavior or personal choice. This excessive tax on beer is not efficient at raising revenue, and the cost of each dollar imposed is much greater in terms of jobs lost and economic drag.

There are, of course, concerns about the social costs of alcohol consumption. I am very sensitive to those concerns and am encouraged by the reductions in drunk driving and alcohol abuse. But the fact is, this tax punishes all beer consumers instead of the minority who act dangerously. In any case, these problems must be addressed directly through specific legislation rather than indirectly through the Tax Code, which is already complicated enough.

Mr. President, because this tax has grown so much since 1991 and because it not only affects beer wholesalers and resellers but hard-working Montanans who enjoy these products responsibly, I am pleased to cosponsor this legislation in the Senate.

PASSING THE MINIMUM WAGE

Mr. BIDEN. Mr. President, every day we see more evidence that this economy is not working for millions of Americans. One troubling trend is the growing divide between rich and poor the widening gap in income inequality and the distribution of wealth in our country.

Over the past 24 years, the most fortunate Americans, in the top 1 percent, saw their incomes more than double from an average of $306,000 to over $700,000. During that same period, the incomes of average Americans grew just 15 percent.

But the poorest fifth of our citizens saw their already inadequate incomes grow just $600—over 24 years.

As a result, the top 1 percent of Americans now get over 12 percent of all the income, up over 50 percent 24 years ago. And the share of the average family actually dropped. The share going to the bottom fifth dropped even more.

We are moving apart, not coming together, as a nation. Last year, the Chair of the Federal Reserve called growing concentration of income in the hands of a tiny minority ''a really serious problem.''

There are many things we need to do to get our economy working for working families. One place to start is at the bottom among those Americans who work at full-time jobs and remain below the poverty line. We should not permit that to happen. If we honor work, we have to reward it. We should not stand for any American to work a full-time job and come home too poor to meet the basic needs.

The minimum wage has not increased since 1996—and all of that increase has been wiped out by the cost of living. The minimum wage today, at $5.15 an hour, is even worth less in today's dollars than the $4.25 rate it replaced.

Today, the minimum wage is worth only a third of the average hourly wage of American workers, the lowest level in more than half a century. The bottom rung of the ladder of opportunity is broken. It is time to fix it.

That is why I am a cosponsor of S. 1062, which will raise the minimum wage in three stages, over the next 3 years, to $7.25 an hour.

That means a pay raise for over 7 million workers and lifting the floor under everybody's wages.

It has been 10 years since we last raised the minimum wage. Over the past few years, we have passed tax cuts that last year alone gave over $100,000 to the wealthiest among us. The gap between rich and poor is now as big as it was during the Great Depression.

Raising the minimum wage is only the first step in restoring balance and fairness to our economy. But it is past time for us to take that step. We must not wait any longer.

BE KIND TO ANIMALS WEEK

Mr. ALLARD. Mr. President, I am pleased to announce that this week, May 7 to 13, 2006, has been designated by the American Humane Association as the 92nd Be Kind to Animals Week. The American Humane Association, which is headquartered in Englewood, CO, was founded in 1877 and is the oldest national organization dedicated to the mission of preventing cruelty to animals, as well as to children. Through this work, American Humane has helped America shed light on the nature and origins of cruelty and through this annual observance reminds us that the practice of kindness can both heal hurt and yield constructive reform.

When, in 1915, American Humane launched the Nation's first national week for animals, its purpose was simple: ''to direct the attention of the public to the importance of giving proper care and attention to animals.'' This message resonated powerfully with Americans and quickly evolved into a national public education campaign with a broader mission: promoting the teaching of humane education in our schools; promoting the good works of animal shelters; and helping Americans understand the unique bond between humans and animals.

Be Kind to Animals Week is the oldest event of its kind. Each year it reminds us how animals enrich our lives through their companionship, friendship and love. Over the last 91 years, a central theme of this annual event has been the importance of teaching the principles of kindness and compassion to children. Humane groups spend much of their time reacting to mistreatment of animals as it occurs. American Humane believes that, if we share our humane values with our children, these problems can be prevented and our society made safer and kinder.

American Humane's Be Kind to Animals Week is as much a lifelong attitude as it is a weeklong event. It is about animal shelters, veterinarians, humane educators, animal control professionals, and the faith community promoting discussion and reflection about kindness to animals, to individuals, within families and perhaps most important, within communities. But Be Kind to Animals Week isn't just about animals. It is also about children and those who care for and about them.

As a veterinarian, I have seen firsthand how important animals are to people. When a family adopts a pet, it becomes one of them. Usually, when people bring an animal to a veterinarian, it is because there is something wrong with the animal. It was always obvious to me the love that people had for their animals. The illness of a pet can cause great sorrow, but the healing of a pet brings great joy. Many studies have shown the increased happiness and healing powers of spending time with a pet.

During Be Kind to Animals Week, we should all keep in mind a simple but powerful message. The week should serve as a reminder that as humans, we need to be ever more compassionate about the animals in our world, whether they are companion pets, service animals such as seeing-eye dogs, zoo critters, livestock, or nature's wildlife. It is a reminder that the bond between humans and animals is a vital one and is capable of bringing joy and healing to people of all ages. It is also a reminder to be more kind and compassionate to our fellow man. We co-exist in this world—human to human and human to animal—and those bonds must be maintained, they must be kept strong.

ADDITIONAL STATEMENTS

HONORING SIGNATURE SCHOOL

• Mr. BAYH. Mr. President, I rise today to pay tribute to Evanville's Signature School, which was recently ranked by Newsweek Magazine as one of the top one hundred high schools in the Nation. This ranking is a remarkable honor to the school, and it demonstrates the hard work and dedication to educational excellence of the students and teachers at Signature.

I am honored to have the opportunity to commend the achievements of Signature's students and the commitment of Signature's families and teachers, which made this prestigious recognition possible. Now more than ever, education is the key to greater personal opportunity. Here in Washington, I have fought to ensure that education is available and accessible to all our Nation's students. However, the real, heroic work is done on the ground, in our schools. The Signature School is a perfect example of what can happen when teachers and students unite around the goal of achieving academic excellence.

Signature was the first charter school in Indiana, created to offer a

challenging curriculum and nurturing educational environment to its students. Signature was a half-day program offering accelerated courses for a decade, before the passage of Indiana's charter school law, allowing Signature to become a full-day, independent charter school in 2002. Since then, Signature has been able to focus full-time on offering Evansville students the opportunity to compete at a national level. As Newsweek's rankings demonstrate, the school has certainly succeeded in accomplishing its mission.

I wish to take a moment to pay special tribute to Signature's teachers and principal, Vicki Schneider. With their focus on quality education and dedication to their students, every teacher and staff person at Signature has helped ensure that their graduates have the necessary tools to excel in today's increasingly competitive world. This summer, as Signature's graduates take the next step in their lives, they do so well-prepared to assume the mantle of leadership for their generation. I look forward to following their future successes, and I hope they will remember their extraordinary education and someday return the favor and give back to the youth of our country so that they can enjoy similar opportunities.●

IN RECOGNITION OF DELTA TAU DELTA'S BETA PHI CHAPTER

● Mr. CARPER. Mr. President. I rise today to recognize the Beta Phi Chapter of Delta Tau Delta for their reinstatement to the Ohio State University's fraternity system and for the chapter's commitment to living lives of excellence that can serve as an example for us all.

Founded at Bethany College in 1858, Delta Tau Delta began as a response by the eight founding members to suspicions that the student-run Neotrophian Literary Society had been compromised and that the results of a student oratory contest had been manipulated. This injustice was not to be tolerated by the young founding members, as they were devoted to the idea of truth in all matters. Their response was to found the fraternal society of Delta Tau Delta, which continues to thrive on college campuses across America.

This devotion to the truth is only one of the hallmarks of Delta Tau Delta. The ideals of courage, faith and power complete the quartet of founding principles. These guiding lights have illuminated the lives of many extraordinary young men who have undertaken the commitment that is required to become an active member of this outstanding organization.

Those men have gone on to serve in positions of trust and great responsibility today as CEOs of companies like GM and General Mills, as Governor of New Mexico, as U.S. Representatives, and as U.S. Senators of South Dakota and Delaware.

The Beta Phi chapter at the Ohio State University was founded on November 19, 1894. More than 2,000 young men have forged their college memories there through their participation in this chapter. Located less than 200 yards from campus, the Delta Tau Delta house stood for much of the past century as a testament to character, honesty, and integrity. The reinstatement of the Beta Phi chapter represents a return to those values.

These bonds of brotherhood do not dissolve at graduation. They continue through time because the brothers of Delta Tau Delta commit themselves to a cause that is larger than a single individual or graduating class.

With chapters on more than 200 college campuses across America and approximately 6,000 active members and more than 145,000 alumni, Delta Tau Delta has had an immeasurable impact on the communities in which its members—past and present—live and serve. Volunteer service is vital to the improvement of any community. It is one of the primary requirements for becoming an active member of Delta Tau Delta. By partnering with the Adopt-A-School volunteer service organization, the men of the Beta Phi Chapter have lent their time and energy at every turn to mentor and tutor thousands of schoolchildren less fortunate than they.

The Delta Tau Delta experience also allows young men to gain experience that the average college student does not receive by providing members with opportunities for responsibility and leadership that are not easily found in the many traditional college settings. Whether mentoring school children or organizing a community blood drive, the men of Delta Tau Delta accept responsibility for more than themselves. They learn to give back to their communities and strive for excellence at every opportunity.

With this proud tradition in mind, the men of Delta Tau Delta's Beta Phi chapter are to be commended and applauded for their reinstatement to the Ohio State University community and for this chapter's return to the principles on which it was founded more than a century ago.●

IN RECOGNITION OF RETHA FISHER'S RETIREMENT

● Mr. CARPER. Mr. President. I rise to today in recognition of Retha Fisher upon her retirement. Retha has served as Westminster Presbyterian Church's director of social services for 29 years, and her leadership over that span of time has won her the respect and gratitude of our entire State. She has been, and remains, a trusted friend to many members of our congregation and of the community that we serve.

Retha was born in Fayetteville, NC, on April 18, 1936. She was the only child of Clara and Lester McLerin. Her early childhood ambition was to become a nurse, but she decided against it because she disliked the sight of blood. After many years of piano and voice lessons, she began her college career in Washington, DC, at Howard University where she majored in music. She later decided to follow her childhood desire to help her fellow man and changed her major to psychology and sociology with a minor in English. It was during this time that she made the decision to become a social worker.

After graduation and while looking for employment, Retha applied to what was then known as the State Department of Welfare, Child Welfare Division in Dover. During the interview process, she was asked if she would like to take advantage of a stipend to attend graduate school. While living in Wilmington, she attended the University of Pennsylvania's School of Social Work and was placed in a position in Dover. Her placement was with Child Welfare Services, and she soon discovered that working with children was her true calling. Twelve years later, Retha accepted a position with the Wilmington Housing Authority as their coordinator of social services.

Throughout these many years doing her fine work, Retha maintained and nourished some other ''loves of her life.'' She met and married Arland Roland Fisher, whom everyone called Roland. Together they had one daughter, Whitney Gayle Fisher, who now practices personal injury and criminal law in Newark, NJ. After her daughter's birth, Retha left her position to with the Wilmington Housing Authority to devote her time as a full-time wife and mother.

In 1977, though, Retha was asked by Westminster Presbyterian Church if she would be interested in interviewing for a job there. It was with this wonderful opportunity that Retha found her true calling. She became the church's director of social services, and the people of Westminster and of Delaware have been truly blessed by this decision for almost three decades.

Retha's service has extended far beyond the church walls and well into the community. In 1993, she founded the Food Bank of Delaware, a nonprofit agency that helps feed hungry people throughout our State. The Food Bank of Delaware is the only facility in Delaware with the equipment, warehouse, and staff to collect donations for all sectors of the food industry and to safely and efficiently redistribute it to the people who need it most. Through 235 member agencies, the Food Bank of Delaware distributes over 10 million pounds of food annually.

In addition to the Food Bank of Delaware, Retha has also helped countless low-income individuals with financial assistance. She founded F.A.I.T.H. Center, which provides financial assistance to the poor. In 1992, she also chaired the Conectiv—now Delmarva Power—Consumer Council, which continues to meet with representatives of the utility and the State of Delaware to bring financial support to those who cannot afford to pay their utility bills.

In 1989, Retha met with 10 Westminster couples to explore the possibility of how they might help homeless families get off the street and into adequate housing. To that end, Retha founded the Samaritans. From case management to furniture to mentoring, the Samaritans stand ready to provide support for the year or so that a homeless family needs to become stabilized.

At Christmastime, Retha embodies the true spirit of the holidays. Each year, Retha organizes and oversees Westminster's yearly program to distribute Christmas food and gift baskets to nearly 200 clients of the social services agencies of greater Wilmington.

Retha has not only brought financial assistance through her work in these various programs, but she has served as a spiritual leader as well. She has been an ear to the lonely and a person to pray with through the hard times. She has given each of these people who have come to her dignity and hope.

Through Retha's tireless efforts, she has made a profound difference in the lives of thousands of Delawareans. Upon her retirement, she leaves behind a legacy of commitment to public service for future generations to follow. I thank her for the friendship that many of us are privileged to share with Retha and for the inspiration that she provides through a lifetime of caring. On behalf of all Delawareans, I congratulate her on a truly remarkable and distinguished career and extend to her my very best wishes for every success in the future. I wish her and her family only the very best in all that lies ahead.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. STEVENS, from the Committee on Commerce, Science, and Transportation, with an amendment in the nature of a substitute:

S. 2389. A bill to amend the Communications Act of 1934 to prohibit the unlawful acquisition and use of confidential customer proprietary network information, and for other purposes (Rept. No. 109–253).

By Mr. WARNER, from the Committee on Armed Services, without amendment:

S. 2766. An original bill to authorize appropriations for fiscal year 2007 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes (Rept. No. 109–254).

S. 2767. An original bill to authorize appropriations for fiscal year 2007 for military activities of the Department of Defense, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes.

S. 2768. An original bill to authorize appropriations for fiscal year 2007 for military construction, and for other purposes.

S. 2769. An original bill to authorize appropriations for fiscal year 2007 for defense activities of the Department of Energy, and for other purposes.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. DODD (for himself and Mr. SMITH):

S. 2765. A bill to provide assistance to improve the health of newborns, children, and mothers in developing countries, and for other purposes; to the Committee on Foreign Relations.

By Mr. WARNER:

S. 2766. An original bill to authorize appropriations for fiscal year 2007 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes; from the Committee on Armed Services; placed on the calendar.

By Mr. WARNER:

S. 2767. An original bill to authorize appropriations for fiscal year 2007 for military activities of the Department of Defense, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes; from the Committee on Armed Services; placed on the calendar.

By Mr. WARNER:

S. 2768. An original bill to authorize appropriations for fiscal year 2007 for military construction, and for other purposes; from the Committee on Armed Services; placed on the calendar.

By Mr. WARNER:

S. 2769. An original bill to authorize appropriations for fiscal year 2007 for defense activities of the Department of Energy, and for other purposes; from the Committee on Armed Services; placed on the calendar.

By Mr. McCAIN (for himself, Mr. BIDEN, Mr. LIEBERMAN, and Mr. LEAHY):

S. 2770. A bill to impose sanctions on certain officials of Uzbekistan responsible for the Andijan massacre; to the Committee on Foreign Relations.

By Mr. VITTER:

S. 2771. A bill to increase the types of Federal housing assistance available to individuals and households in response to a major disaster, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

By Mr. VOINOVICH (for himself, Mr. BINGAMAN, Mr. DEWINE, and Mr. AKAKA):

S. 2772. A bill to provide for innovation in health care through State initiatives that expand coverage and access and improve quality and efficiency in the health care system; to the Committee on Health, Education, Labor, and Pensions.

By Mrs. BOXER:

S. 2773. A bill to require the Federal Government to purchase fuel efficient automobiles, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. COLEMAN (for himself, Ms. LANDRIEU, and Mr. CRAIG):

S. Res. 471. A resolution recognizing that, during National Foster Care Month, the leaders of the Federal, State, and local governments should provide leadership to improve the care given to children in foster care programs; considered and agreed to.

ADDITIONAL COSPONSORS

S. 185

At the request of Mr. NELSON of Florida, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 185, a bill to amend title 10, United States Code, to repeal the requirement for the reduction of certain Survivor Benefit Plan annuities by the amount of dependency and indemnity compensation and to modify the effective date for paid-up coverage under the Survivor Benefit Plan.

S. 401

At the request of Mr. HARKIN, the names of the Senator from Hawaii (Mr. INOUYE) and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of S. 401, a bill to amend title XIX of the Social Security Act to provide individuals with disabilities and older Americans with equal access to community-based attendant services and supports, and for other purposes.

S. 713

At the request of Mr. ROBERTS, the name of the Senator from Idaho (Mr. CRAIG) was added as a cosponsor of S. 713, a bill to amend the Internal Revenue Code of 1986 to provide for collegiate housing and infrastructure grants.

S. 722

At the request of Mr. SANTORUM, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 722, a bill to amend the Internal Revenue Code of 1986 to reduce the tax on beer to its pre-1991 level.

S. 1278

At the request of Mr. LEAHY, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 1278, a bill to amend the Immigration and Nationality Act to provide a mechanism for United States citizens and lawful permanent residents to sponsor their permanent partners for residence in the United States, and for other purposes.

S. 1537

At the request of Mr. AKAKA, the names of the Senator from Illinois (Mr.

OBAMA) and the Senator from Washington (Mrs. MURRAY) were added as cosponsors of S. 1537, a bill to amend title 38, United States Code, to provide for the establishment of Parkinson's Disease Research Education and Clinical Centers in the Veterans Health Administration of the Department of Veterans Affairs and Multiple Sclerosis Centers of Excellence.

S. 1698

At the request of Mr. KERRY, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 1698, a bill to accelerate efforts to develop vaccines for diseases primarily affecting developing countries and for other purposes.

S. 1774

At the request of Mr. CORNYN, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 1774, a bill to amend the Public Health Service Act to provide for the expansion, intensification, and coordination of the activities of the National Heart, Lung, and Blood Institute with respect to research on pulmonary hypertension.

S. 1934

At the request of Mr. SPECTER, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 1934, a bill to reauthorize the grant program of the Department of Justice for reentry of offenders into the community, to establish a task force on Federal programs and activities relating to the reentry of offenders into the community, and for other purposes.

S. 2039

At the request of Mr. DURBIN, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. 2039, a bill to provide for loan repayment for prosecutors and public defenders.

S. 2306

At the request of Mr. LEVIN, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 2306, a bill to amend the National Organ Transplant Act to clarify that kidney paired donation and kidney list donation do not involve the transfer of a human organ for valuable consideration.

S. 2321

At the request of Mr. SANTORUM, the names of the Senator from North Dakota (Mr. DORGAN), the Senator from North Carolina (Mrs. DOLE) and the Senator from Wyoming (Mr. THOMAS) were added as cosponsors of S. 2321, a bill to require the Secretary of the Treasury to mint coins in commemoration of Louis Braille.

S. 2452

At the request of Mr. BAYH, the name of the Senator from Nebraska (Mr. HAGEL) was added as a cosponsor of S. 2452, a bill to prohibit picketing at the funerals of members and former members of the armed forces.

S. 2491

At the request of Mr. CORNYN, the name of the Senator from Idaho (Mr. CRAIG) was added as a cosponsor of S. 2491, a bill to award a Congressional gold medal to Byron Nelson in recognition of his significant contributions to the game of golf as a player, a teacher, and a commentator.

S. 2510

At the request of Mr. DURBIN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 2510, a bill to establish a national health program administered by the Office of Personnel Management to offer health benefits plans to individuals who are not Federal employees, and for other purposes.

S. 2554

At the request of Mr. ENSIGN, the name of the Senator from South Carolina (Mr. GRAHAM) was added as a cosponsor of S. 2554, a bill to amend the Internal Revenue Code of 1986 to expand the permissible use of health savings accounts to include premiums for non-group high deductible health plan coverage.

S. 2562

At the request of Mr. CRAIG, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 2562, a bill to increase, effective as of December 1, 2006, the rates of compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for the survivors of certain disabled veterans.

S. 2644

At the request of Mrs. FEINSTEIN, the name of the Senator from Delaware (Mr. BIDEN) was added as a cosponsor of S. 2644, a bill to harmonize rate setting standards for copyright licenses under sections 112 and 114 of title 17, United States Code, and for other purposes.

S. 2652

At the request of Mrs. FEINSTEIN, the name of the Senator from Colorado (Mr. ALLARD) was added as a cosponsor of S. 2652, a bill to amend chapter 27 of title 18, United States code, to prohibit the unauthorized construction, financing, or, with reckless disregard, permitting the construction or use on one's land, of a tunnel or subterranean passageway between the United States and another country.

S. 2658

At the request of Mr. BOND, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 2658, a bill to amend title 10, United States Code, to enhance the national defense through empowerment of the Chief of the National Guard Bureau and the enhancement of the functions of the National Guard Bureau, and for other purposes.

At the request of Mr. LEAHY, the names of the Senator from Nevada (Mr. REID) and the Senator from Louisiana (Ms. LANDRIEU) were added as cosponsors of S. 2658, supra.

S. 2674

At the request of Mr. AKAKA, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 2674, a bill to amend the Native American Languages Act to provide for the support of Native American language survival schools, and for other purposes.

S. 2692

At the request of Mr. LEVIN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 2692, a bill to suspend temporarily the duty on certain microphones used in automotive interiors.

S. 2694

At the request of Mr. CRAIG, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of S. 2694, a bill to amend title 38, United States Code, to remove certain limitations on attorney representation of claimants for veterans benefits in administrative proceedings before the Department of Veterans Affairs, and for other purposes.

S. 2697

At the request of Mr. LUGAR, the name of the Senator from Missouri (Mr. BOND) was added as a cosponsor of S. 2697, a bill to establish the position of the United States Ambassador for ASEAN.

S. 2703

At the request of Mr. LEAHY, the names of the Senator from Wisconsin (Mr. FEINGOLD), the Senator from Indiana (Mr. BAYH) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. 2703, a bill to amend the Voting Rights Act of 1965.

S. 2704

At the request of Mr. DEWINE, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. 2704, a bill to revise and extend the National Police Athletic League Youth Enrichment Act of 2000.

S. 2723

At the request of Mr. LAUTENBERG, the name of the Senator from Colorado (Mr. SALAZAR) was added as a cosponsor of S. 2723, a bill to amend title XVIII of the Social Security Act to require the sponsor of a prescription drug plan or an organization offering an MA-PD plan to promptly pay claims submitted under part D, and for other purposes.

S. 2725

At the request of Mrs. CLINTON, the names of the Senator from Indiana (Mr. BAYH) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of S. 2725, a bill to amend the Fair Labor Standards Act of 1938 to provide for an increase in the Federal Minimum wage and to ensure that increases in the Federal minimum wage keep pace with any pay adjustments for Members of Congress.

S. 2754

At the request of Mr. SANTORUM, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor of S. 2754, a bill to derive human pluripotent stem cell lines using techniques that do not knowingly harm embryos.

S. 2759

At the request of Mr. SMITH, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 2759, a bill to provide for additional outreach and education related to the Medicare program and to amend title XVIII of the Social Security Act to provide a special enrollment period for individuals who qualify for an income-related subsidy under the Medicare prescription drug program.

S. RES. 320

At the request of Mr. ENSIGN, the names of the Senator from New York (Mrs. CLINTON) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of S. Res. 320, a resolution calling the President to ensure that the foreign policy of the United States reflects appropriate understanding and sensitivity concerning issues related to human rights, ethnic cleansing, and genocide documented in the United States record relating to the Armenian Genocide.

S. RES. 436

At the request of Mr. MCCAIN, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. Res. 436, a resolution urging the Federation Internationale de Football Association to prevent persons or groups representing the Islamic Republic of Iran from participating in sanctioned soccer matches.

S. RES. 469

At the request of Mr. LIEBERMAN, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of S. Res. 469, a resolution condemning the April 25, 2006, beating and intimidation of Cuban dissident Martha Beatriz Roque.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

Mr. DODD (for himself and Mr. SMITH):

S. 2765. A bill to provide assistance to improve the health of newborns, children, and mothers in developing countries, and for other purposes; to the Committee on Foreign Relations.

Mr. President, I rise today to introduce, on behalf of myself and my friend, Senator GORDON SMITH of Oregon, the Child Health Investment for Long-term Development (CHILD and Newborn) Act of 2006. This legislation would perform four simple, yet critically important functions.

First, it would require the Administration to develop and implement a strategy to improve the health of, and reduce mortality rates among, newborns, children, and mothers in developing countries.

Second, it would mandate the establishment of a U.S. Government task force to assess, monitor, and evaluate the progress of U.S. efforts to meet the United Nations Millennium Development Goals by 2015—specifically as those goals relate to reducing mortality rates for mothers and for children less than 5 years of age in developing countries.

Third, it would authorize the President to furnish assistance for programs whose goal is to improve the health of newborns, children, and mothers in developing countries.

And fourth, this legislation would authorize appropriations to carry out its provisions—$660 million for fiscal year 2007, and $1.2 billion for each of fiscal years 2008–2011.

I know that some of my colleagues will look at this bill and ask why the U.S. should devote such large amounts of resources to combating child and maternal mortality in the developing world. Certainly, nobody would deny that it's an important cause, but should it really be this much of a priority?

I would argue that the answer to this is yes. Why? Because with U.S. leadership, the current reality for mothers and their young children in the developing world can be changed dramatically.

What is that reality?

Almost 11 million children under the age of 5 die every year in the developing world—that's approximately 30,000 each day. About four million of those children die in their first four weeks of life. In many cases, they aren't even provided with a fighting chance. Indeed, for children under the age of five in the developing world, preventable or treatable diseases such as measles, tetanus, diarrhea, pneumonia, and malaria are the most common causes of death.

Each year, more than 525,000 women die from causes related to pregnancy and childbirth—more than 1,400 each day. Ninety-nine percent of these deaths occur in the developing world. And the lifetime risk of an African woman dying from a pregnancy or childbirth-related complication is I in 16, a high level of risk that is all the more striking when compared to the same risk for women in more developed regions—1 in 2,800. Some of the most common risk factors for maternal death in developing countries include early pregnancy and childbirth, closely spaced births, infectious diseases, malnutrition, and complications during childbirth.

Mr. President, the deaths of these nearly 12 million mothers and children are from largely preventable causes. This is a tragic situation, and it shouldn't be the case.

Luckily, we can combat these high levels of mortality—and it won't require lots of sophisticated technology. Instead, it will require simple measures that we take for granted here in the developed world.

For instance, it is estimated that two-thirds of deaths among children under 5 years of age—that's 7.1 million children, including 3 million newborns—could be prevented by low-cost, low-tech health and nutritional interventions. These interventions include encouraging breastfeeding; providing vitamin supplements, immunizations, and antibiotics; offering oral rehydration therapy with clean water; and expansion of basic clinical care.

For expecting mothers, simple steps such as birth spacing, access to preventive care, skilled birth attendants, and emergency obstetric care can help reduce maternal morality rates. And keeping mothers healthy is critical because the welfare of newborns and infants is inextricably tied to the health of the mother.

Mr. President, the U.S. isn't new at this battle. Over the past 30 years, our work in promoting child survival and maternal health globally has resulted in millions of lives being saved.

And in 2000, the U.S. joined 188 other countries in supporting eight Millennium Development Goals laid out by the United Nations. Two of these goals are related to child and maternal health—one calls for a reduction by two-thirds in the mortality rate of children under 5, and the other calls for a reduction in maternal deaths by three-quarters. Both of these goals are targeted to be met by 2015.

But with current structures and at current funding levels, the world is unlikely to meet these laudable goals. Certainly, the U.S. can't meet these global needs alone. Addressing this critical issue can't be a unilateral effort—countries around the world must also do their part and come forward with much-needed funding.

But passing the CHILD and Newborn Act of 2006 would send a strong message to the international community that this is a priority issue, and it would encourage them to step up to the plate. Millions of lives could be saved in the process.

On September 14, 2005, President Bush stated that the U.S. is ''committed to the Millennium Development Goals.'' I commend the President for his words. But now, it is time for Congress to stand up and make sure that the U.S. fulfills this commitment to protect millions of innocent women and their children around the globe. I urge my colleagues to support this bill.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2765

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Child Health Investment for Long-term Development (CHILD and Newborn) Act of 2006''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds the following:

(1) Around the world, approximately 10.8 million children under the age of five die each year, more than 30,000 per day, almost all in the developing world.

(2) Each year in the developing world, four million newborns die in their first four weeks of life.

(3) Sub-Saharan Africa, with only 10 percent of the world's population, accounts for 43 percent of all deaths among children under the age of five.

(4) Countries such as Afghanistan, Angola and Niger experience extreme levels of child mortality, with 25 percent of children dying before their fifth birthday.

(5) For children under the age of five in the developing world, preventable or treatable diseases, such as measles, tetanus, diarrhea, pneumonia, and malaria, are the most common causes of death.

(6) Throughout the developing world, the lack of basic health services, clean water, adequate sanitation, and proper nutrition contribute significantly to child mortality.

(7) Hunger and malnutrition contribute to over five million child deaths annually.

(8) The lack of low-cost antibiotics and anti-malarial drugs contribute to three million child deaths each year.

(9) Lack of access to health services results in 30 million children under the age of one year going without necessary immunizations.

(10) Every year an estimated 250,000 to 500,000 vitamin A-deficient children become blind, with one-half of such children dying within 12 months of losing their sight.

(11) Iron deficiency, affecting over 30 percent of the world's population, causes premature birth, low birth weight, and infections, elevating the risk of death in children.

(12) Two-thirds of deaths of children under five years of age, or 7.1 million children, including three million newborn deaths, could be prevented by low-cost, low-tech health and nutritional interventions.

(13) Exclusive breastfeeding—giving only breast milk for the first six months of life—could prevent an estimated 1.3 million newborn and infant deaths each year, primarily by protecting against diarrhea and pneumonia.

(14) An additional two million lives could be saved annually by providing oral-rehydration therapy prepared with clean water.

(15) During the 1990s, successful immunization programs reduced polio by 99 percent, tetanus deaths by 50 percent, and measles cases by 40 percent.

(16) Between 1998 and 2000, distribution of low-cost vitamin A supplements saved an estimated one million lives.

(17) Expansion of clinical care of newborns and mothers, such as clean delivery by skilled attendants, emergency obstetric care, and neonatal resuscitation, can avert 50 percent of newborn deaths.

(18) Keeping mothers healthy is essential for child survival because illness, complications, or maternal death during or following pregnancy increases the risk for death in newborns and infants.

(19) Each year more than 525,000 women die from causes related to pregnancy and childbirth, with 99 percent of these deaths occurring in developing countries.

(20) The lifetime risk of an African woman dying from a complication related to pregnancy or childbirth is 1 in 16, while the same risk for a woman in a developed country is 1 in 2,800.

(21) Risk factors for maternal death in developing countries include early pregnancy and childbirth, closely spaced births, infectious diseases, malnutrition, and complications during childbirth.

(22) Birth spacing, access to preventive care, skilled birth attendants, and emergency obstetric care can help reduce maternal mortality.

(23) The role of the United States in promoting child survival and maternal health over the past three decades has resulted in millions of lives being saved around the world.

(24) In 2000, the United States joined 188 other countries in supporting eight Millennium Development Goals designed to achieve ''a more peaceful, prosperous and just world''.

(25) Two of the Millennium Development Goals call for a reduction in the mortality rate of children under the age of five by two-thirds and a reduction in maternal deaths by three-quarters by 2015.

(26) On September 14, 2005, President George W. Bush stated before the leaders of the world: ''To spread a vision of hope, the United States is determined to help nations that are struggling with poverty. We are committed to the Millennium Development Goals.''.

(b) PURPOSES.—The purposes of this Act are to—

(1) authorize assistance to improve the health of newborns, children, and mothers in developing countries, including by strengthening the capacity of health systems and health workers;

(2) develop and implement a strategy to improve the health of newborns, children, and mothers, including reducing child and maternal mortality, in developing countries;

(3) to establish a task force to assess, monitor, and evaluate the progress and contributions of relevant departments and agencies of the Government of the United States in achieving the United Nations Millennium Development Goals by 2015 for reducing the mortality of children under the age of five by two-thirds and reducing maternal mortality by three-quarters in developing countries.

SEC. 3. ASSISTANCE TO IMPROVE THE HEALTH OF NEWBORNS, CHILDREN, AND MOTHERS IN DEVELOPING COUNTRIES.

(a) IN GENERAL.—Chapter 1 of part I of the Foreign Assistance Act of 1961 (22 U.S.C. 2151 et seq.) is amended—

(1) in section 104(c)—

(A) by striking paragraphs (2) and (3); and

(B) by redesignating paragraph (4) as paragraph (2);

(2) by redesignating sections 104A, 104B, and 104C as sections 104B, 104C, and 104D, respectively; and

(3) by inserting after section 104 the following new section:

''SEC. 104A. ASSISTANCE TO IMPROVE THE HEALTH OF NEWBORNS, CHILDREN, AND MOTHERS.

''(a) AUTHORIZATION.—Consistent with section 104(c), the President is authorized to furnish assistance, on such terms and conditions as the President may determine, to improve the health of newborns, children, and mothers in developing countries.

''(b) ACTIVITIES SUPPORTED.—Assistance provided under subsection (b) shall, to the maximum extent practicable, be used to carry out the following activities:

''(1) Activities to strengthen the capacity of health systems in developing countries, including training for clinicians, nurses, technicians, sanitation and public health workers, community-based health workers, midwives and birth attendants, peer educators, and private sector enterprises.

''(2) Activities to provide health care access to underserved and marginalized populations.

''(3) Activities to ensure the supply, logistical support, and distribution of essential drugs, vaccines, commodities, and equipment to regional, district, and local levels.

''(4) Activities to educate underserved and marginalized populations to seek health care when appropriate, including clinical and community-based activities.

''(5) Activities to integrate and coordinate assistance provided under this section with existing health programs for—

''(A) the prevention of the transmission of HIV from mother-to-child and other HIV/AIDS counseling, care, and treatment activities;

''(B) malaria;

''(C) tuberculosis; and

''(D) child spacing.

''(6) Activities to expand access to safe water and sanitation.

''(7) Activities to expand the use of and technical support for appropriate technology to reduce acute respiratory infection from firewood smoke inhalation.

''(c) GUIDELINES.—To the maximum extent practicable, programs, projects, and activities carried out using assistance provided under this section shall be—

''(1) carried out through private and voluntary organizations, as well as faith-based organizations, giving priority to organizations that demonstrate effectiveness and commitment to improving the health of newborns, children, and mothers;

''(2) carried out with input by host countries, including civil society and local communities, as well as other donors and multilateral organizations;

''(3) carried out with input by beneficiaries and other directly affected populations, especially women and marginalized communities; and

''(4) designed to build the capacity of host country governments and civil society organizations.

''(d) ANNUAL REPORT.—Not later than January 31 of each year, the President shall transmit to Congress a report on the implementation of this section for the prior fiscal year.

''(e) DEFINITIONS.—In this section:

''(1) AIDS.—The term 'AIDS' has the meaning given the term in section 104B(g)(1) of this Act.

''(2) HIV.—The term 'HIV' has the meaning given the term in section 104B(g)(2) of this Act.

''(3) HIV/AIDS.—The term 'HIV/AIDS' has the meaning given the term in section 104B(g)(3) of this Act.''.

(b) CONFORMING AMENDMENTS.—The Foreign Assistance Act of 1961 (22 U.S.C. 2151 et seq.) is amended—

(1) in section 104(c)(2) (as redesignated by subsection (a)(1)(B) of this section), by striking ''and 104C'' and inserting ''104C, and 104D'';

(2) in section 104B (as redesignated by subsection (a)(2) of this section)—

(A) in subsection (c)(1), by inserting ''and section 104A'' after ''section 104(c)'';

(B) in subsection (e)(2), by striking ''section 104B, and section 104C'' and inserting ''section 104C, and section 104D''; and

(C) in subsection (f), by striking ''section 104(c), this section, section 104B, and section 104C'' and inserting ''section 104(c), section 104A, this section, section 104C, and section 104D'';

(3) in subsection (c) of section 104C (as redesignated by subsection (a)(2) of this section), by inserting ''and section 104A'' after ''section 104(c)'';

(4) in subsection (c) of section 104D (as redesignated by subsection (a)(2) of this section), by inserting ''and section 104A'' after ''section 104(c)''; and

(5) in the first sentence of section 119(c), by striking ''section 104(c)(2), relating to Child Survival Fund'' and inserting ''section 104A''.

SEC. 4. DEVELOPMENT OF STRATEGY TO IMPROVE THE HEALTH OF NEWBORNS, CHILDREN, AND MOTHERS IN DEVELOPING COUNTRIES.

(a) DEVELOPMENT OF STRATEGY.—The President shall develop a comprehensive strategy to improve the health of newborns, children, and mothers, including reducing newborn, child, and maternal mortality, in developing countries.

(b) COMPONENTS.—The strategy developed pursuant to subsection (a) shall include the following:

(1) Programmatic areas and interventions providing maximum health benefits to populations at risk as well as maximum reduction in mortality, including—

(A) costs and benefits of programs and interventions; and

(B) investments needed in identified programs and interventions to achieve the greatest results.

(2) An identification of countries with priority needs for the five-year period beginning on the date of the enactment of this Act based on—

(A) the neonatal mortality rate;

(B) the mortality rate of children under the age of five;

(C) the maternal mortality rate;

(D) the percentage of women and children with limited or no access to basic health care; and

(E) additional criteria for evaluation such as—

(i) the percentage of one-year old children who are fully immunized;

(ii) the percentage of children under the age of five who sleep under insecticide-treated bed nets;

(iii) the percentage of children under the age of five with fever treated with anti-malarial drugs;

(iv) the percentage of children under the age of five who are covered by vitamin A supplementation;

(v) the percentage of children under the age of five with diarrhea who are receiving oral-rehydration therapy and continued feeding;

(vi) the percentage of children under the age of five with pneumonia who are receiving appropriate care;

(vii) the percentage of the population with access to improved sanitation facilities;

(viii) the percentage of the population with access to safe drinking water;

(ix) the percentage of children under the age of five who are underweight for their age;

(x) the percentage of births attended by skilled health care personnel;

(xi) the percentage of women with access to emergency obstetric care;

(xii) the potential for implementing newborn, child, and maternal health interventions at scale; and

(xiii) the demonstrated commitment of countries to newborn, child, and maternal health.

(3) A description of how United States assistance complements and leverages efforts by other donors, as well as builds capacity and self-sufficiency among recipient countries.

(4) An expansion of the Child Survival and Health Grants Program of the United States Agency for International Development to provide additional support programs and interventions determined to be efficacious and cost-effective in improving health and reducing mortality.

(5) Enhanced coordination among relevant departments and agencies of the Government of the United States engaged in activities to improve the health of newborns, children, and mothers in developing countries.

(c) REPORT.—Not later than 180 days after the date of the enactment of this Act, the President shall transmit to Congress a report that contains the strategy described in this section.

SEC. 5. INTERAGENCY TASK FORCE ON CHILD SURVIVAL AND MATERNAL HEALTH IN DEVELOPING COUNTRIES.

(a) ESTABLISHMENT.—There is established a task force to be known as the Interagency Task Force on Child Survival and Maternal Health in Developing Countries (in this section referred to as the ''Task Force'').

(b) DUTIES.—

(1) IN GENERAL.—The Task Force shall assess, monitor, and evaluate the progress and contributions of relevant departments and agencies of the Government of the United States in achieving the Millennium Development Goals by 2015 for reducing the mortality of children under the age of five by two-thirds and reducing maternal mortality by three-quarters in developing countries, including by—

(A) identifying and evaluating programs and interventions that directly or indirectly contribute to the reduction of child and maternal mortality rates;

(B) assessing effectiveness of programs, interventions, and strategies toward achieving the maximum reduction of child and maternal mortality rates;

(C) assessing the level of coordination among relevant departments and agencies of the Government of the United States, the international community, international organizations, faith-based organizations, academic institutions, and the private sector;

(D) assessing the contributions made by United States-funded programs toward achieving the Millennium Development Goals;

(E) identifying the bilateral efforts of other nations and multilateral efforts toward achieving the Millennium Development Goals; and

(F) preparing the annual report required by subsection (f).

(2) CONSULTATION.—To the maximum extent practicable, the Task Force shall consult with individuals with expertise in the matters to be considered by the Task Force who are not officers or employees of the Government of the United States, including representatives of United States-based nongovernmental organizations (including faith-based organizations and private foundations), academic institutions, private corporations, the United Nations Children's Fund (UNICEF), and the World Bank.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Task Force shall be composed of the following members:

(A) The Administrator of the United States Agency for International Development.

(B) The Assistant Secretary of State for Population, Refugees and Migration.

(C) The Coordinator of United States Government Activities to Combat HIV/AIDS Globally.

(D) The Director of the Office of Global Health Affairs of the Department of Health and Human Services.

(E) The Under Secretary for Food, Nutrition and Consumer Services of the Department of Agriculture.

(F) The Chief Executive Officer of the Millennium Challenge Corporation.

(G) The Director of the Peace Corps.

(H) Other officials of relevant departments and agencies of the Federal Government who shall be appointed by the President.

(2) CHAIRPERSON.—The Administrator of the United States Agency for International Development shall serve as chairperson of the Task Force.

(d) MEETINGS.—The Task Force shall meet on a regular basis, not less often than quarterly, on a schedule to be agreed upon by the members of the Task Force, and starting not later than 90 days after the date of the enactment of this Act.

(e) DEFINITION.—In this subsection, the term ''Millennium Development Goals'' means the key development objectives described in the United Nations Millennium Declaration, as contained in United Nations General Assembly Resolution 55/2 (September 2000).

(f) REPORT.—Not later than 120 days after the date of the enactment of this Act, and not later than April 30 of each year thereafter, the Task Force shall submit to Congress and the President a report on the implementation of this section.

SEC. 6. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to carry out this Act, and the amendments made by this Act, $660,000,000 for fiscal year 2007 and $1,200,000,000 for each of the fiscal years 2008 through 2011.

(b) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to the authorization of appropriations under subsection (a) are authorized to remain available until expended.

By Mr. VOINOVICH (for himself, Mr. BINGAMAN, Mr. DEWINE, and Mr. AKAKA):

S. 2772. A bill to provide for innovation in health care through State initiatives that expand coverage and access and improve quality and efficiency in the health care system; to the Committee on Health, Education, Labor, and Pensions.

Mr. VOINOVICH. Mr. President, I rise to speak about a bill my colleague Senator BINGAMAN and I introduced today, the Health Care Partnership Act. For too many years, I have listened to my colleagues on both sides of the aisle talk about the rising cost of health care and the growing number of uninsured Americans. Yet, we have not been able to make much progress here at the Federal level to find a meaningful solution for the dilemma this Nation is facing regarding access to quality, affordable health care. Next to the economy, it is the greatest domestic challenge facing our Nation. In fact, the rising cost of health care is a major part of what is hurting our competitiveness in the global marketplace.

While surveys have indicated that health insurance premiums have stabilized—a 9.2 percent increase in 2006 and 2005 and compared with a 12.3 percent in 2004; 14.7 percent in 2003; and 15.2 percent in 2002—health insurance costs continue to be a significant factor impacting American competitiveness. In addition, the share of costs that individuals have paid for employer sponsored insurance has risen roughly 2 percent each year, from 31.4 percent of health care costs in 2001 to 38.4 percent this year.

In fact, spending on health care in the United States reached $1.9 trillion in 2004—almost 16.5 percent of our GDP—the largest share ever.

Yet, despite all the increases in health care spending some 46 million Americans—15 percent of the population—had no health insurance at some point last year. This number has increased steadily. In 2000, that number was 39.8 million. In 2002 it was 43.6 million.

These statistics are startling and it is time that we do something about them. The bill Senator BINGAMAN and I are introducing today aims to break the log-jam here in Washington and

allow states the freedom to explore with health care reform options. This bill would support state-based efforts to reduce the uninsured and the cost of health care, improve quality, improve access to care, and expand information technology.

I have been in this situation before. As Governor of Ohio, I had to work creatively to expand coverage and deal with increasing health care costs for a growing number of uninsured Ohioans. I am happy to report that we were able to make some progress toward reducing the number of uninsured Ohioans during my time as the head of the state by negotiating with the state unions to move to managed care; by controlling Medicaid costs to the point where from 1995 to 1998, due to good stewardship and management, Ohio ended up underspending on Medicaid without harming families; and implementing the S-CHIP program to provide coverage for uninsured children.

Like we did in Ohio, a number of states are already actively pursuing efforts to reduce the number of their residents who lack adequate health care coverage. The Health Care Partnership Act will build on what states like Massachusetts and others are doing, while providing a mechanism to analyze results and make recommendations for future action at the Federal level.

Under the Health Partnership Act, Congress would authorize grants to individual states, groups of states, and Indian tribes and local governments to carry out any of a broad range of strategies to improve our Nation's health care delivery. The bill creates a mechanism for states to apply for grants to a bipartisan ''State Health Innovation Commission'' housed at the Department of Health and Human Services (HHS). After reviewing the state proposals, the Commission would submit to Congress a list of recommended state applications. The Commission would also recommend the amount of Federal grant money each state should receive to carry out the actions described in their plan.

Most importantly, at the end of the five-year period, the Commission would be required to report to Congress whether the states are meeting the goals of the Act. The Commission would then recommend future action Congress should take concerning overall reform, including whether or not to extend the state program.

I believe it is important that we pass this legislation to provide a platform from which we can have a thoughtful conversation about health care reform here in Washington. Since I have been in the Senate, Congress has made some progress toward improving health care, most notably for our 43 million seniors who now have access to affordable prescription medication through the Medicare Modernization Act. We have also increased funding for community health centers and safety net hospitals that provide health care for the uninsured and under insured; increased the use of technology in our health care delivery system; and improved the safety of medical care by passing a medical errors reporting bill.

Yet, these incremental steps are not enough, and we have been at this too long here in Washington without comprehensive, meaningful results. I ask for my colleagues' support for this bipartisan bill that I hope will move us closer toward a solution to the uninsured.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2772

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Partnership Act''.

SEC. 2. STATE HEALTH REFORM PROJECTS.

(a) PURPOSE; ESTABLISHMENT OF STATE HEALTH CARE EXPANSION AND IMPROVEMENT PROGRAM.—The purposes of the programs approved under this section shall include, but not be limited to—

(1) achieving the goals of increased health coverage and access;

(2) ensuring that patients receive high-quality, appropriate health care;

(3) improving the efficiency of health care spending; and

(4) testing alternative reforms, such as building on the public or private health systems, or creating new systems, to achieve the objectives of this Act.

(b) APPLICATIONS BY STATES, LOCAL GOVERNMENTS, AND TRIBES.—

(1) ENTITIES THAT MAY APPLY.—

(A) IN GENERAL.—A State, in consultation with local governments, Indian tribes, and Indian organizations involved in the provision of health care, may apply for a State health care expansion and improvement program for the entire State (or for regions of the State) under paragraph (2).

(B) REGIONAL GROUPS.—A regional entity consisting of more than one State may apply for a multi State health care expansion and improvement program for the entire region involved under paragraph (2).

(C) DEFINITION.—In this Act, the term ''State'' means the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico. Such term shall include a regional entity described in subparagraph (B).

(2) SUBMISSION OF APPLICATION.—In accordance with this section, each State desiring to implement a State health care expansion and improvement program may submit an application to the State Health Innovation Commission under subsection (c) (referred to in this section as the ''Commission'') for approval.

(3) LOCAL GOVERNMENT APPLICATIONS.—

(A) IN GENERAL.—Where a State declines to submit an application under this section, a unit of local government of such State, or a consortium of such units of local governments, may submit an application directly to the Commission for programs or projects under this subsection. Such an application shall be subject to the requirements of this section.

(B) OTHER APPLICATIONS.—Subject to such additional guidelines as the Secretary may prescribe, a unit of local government, Indian tribe, or Indian health organization may submit an application under this section, whether or not the State submits such an application, if such unit of local government can demonstrate unique demographic needs or a significant population size that warrants a substate program under this subsection.

(c) STATE HEALTH INNOVATION COMMISSION.—

(1) IN GENERAL.—Within 90 days after the date of the enactment of this Act, the Secretary shall establish a State Health Innovation Commission that shall—

(A) be comprised of—

(i) the Secretary;

(ii) four State governors to be appointed by the National Governors Association on a bipartisan basis;

(iii) two members of a State legislature to be appointed by the National Conference of State Legislators on a bipartisan basis;

(iv) two county officials to be appointed by the National Association of Counties on a bipartisan basis;

(v) two mayors to be appointed by the United States Conference of Mayors on a bipartisan basis;

(vi) two individuals to be appointed by the Speaker of the House of Representatives;

(vii) two individuals to be appointed by the Minority Leader of the House of Representatives;

(viii) two individuals to be appointed by the Majority Leader of the Senate;

(ix) two individuals to be appointed by the Minority Leader of the Senate; and

(x) two individuals who are members of federally-recognized Indian tribes to be appointed on a bipartisan basis by the National Congress of American Indians;

(B) upon approval of ⅔ of the members of the Commission, provide the States with a variety of reform options for their applications, such as tax credit approaches, expansions of public programs such as medicaid and the State Children's Health Insurance Program, the creation of purchasing pooling arrangements similar to the Federal Employees Health Benefits Program, individual market purchasing options, single risk pool or single payer systems, health savings accounts, a combination of the options described in this clause, or other alternatives determined appropriate by the Commission, including options suggested by States, Indian tribes, or the public;

(C) establish, in collaboration with a qualified and independent organization such as the Institute of Medicine, minimum performance measures and goals with respect to coverage, quality, and cost of State programs, as described under subsection (d)(1);

(D) conduct a thorough review of the grant application from a State and carry on a dialogue with all State applicants concerning possible modifications and adjustments;

(E) submit the recommendations and legislative proposal described in subsection (d)(4)(B);

(F) be responsible for monitoring the status and progress achieved under program or projects granted under this section;

(G) report to the public concerning progress made by States with respect to the performance measures and goals established under this Act, the periodic progress of the State relative to its State performance measures and goals, and the State program application procedures, by region and State jurisdiction;

(H) promote information exchange between States and the Federal Government; and

(I) be responsible for making recommendations to the Secretary and the Congress, using equivalency or minimum standards, for minimizing the negative effect of State program on national employer groups, provider organizations, and insurers because of

differing State requirements under the programs.

(2) PERIOD OF APPOINTMENT; REPRESENTATION REQUIREMENTS; VACANCIES.—Members shall be appointed for a term of 5 years. In appointing such members under paragraph (1)(A), the designated appointing individuals shall ensure the representation of urban and rural areas and an appropriate geographic distribution of such members. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(3) CHAIRPERSON, MEETINGS.—

(A) CHAIRPERSON.—The Commission shall select a Chairperson from among its members.

(B) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(C) MEETINGS.—Not later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting. The Commission shall meet at the call of the Chairperson.

(4) POWERS OF THE COMMISSION.—

(A) NEGOTIATIONS WITH STATES.—The Commission may conduct detailed discussions and negotiations with States submitting applications under this section, either individually or in groups, to facilitate a final set of recommendations for purposes of subsection (d)(4)(B). Such negotiations shall include consultations with Indian tribes, and be conducted in a public forum.

(B) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this subsection.

(C) MEETINGS.—In addition to other meetings the Commission may hold, the Commission shall hold an annual meeting with the participating States under this section for the purpose of having States report progress toward the purposes in subsection (a)(1) and for an exchange of information.

(D) INFORMATION.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this subsection. Upon request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission if the head of the department or agency involved determines it appropriate.

(E) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(5) PERSONNEL MATTERS.—

(A) COMPENSATION.—Each member of the Commission who is not an officer or employee of the Federal Government or of a State or local government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(B) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(C) STAFF.—The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(D) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(E) TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(6) FUNDING.—For the purpose of carrying out this subsection, there are authorized to be appropriated $3,000,000 for fiscal year 2006 and each fiscal year thereafter.

(d) REQUIREMENTS FOR PROGRAMS.—

(1) STATE PLAN.—A State that seeks to receive a grant under subsection (f) to operate a program under this section shall prepare and submit to the Commission, as part of the application under subsection (b), a State health care plan that shall have as its goal improvements in coverage, quality and costs. To achieve such goal, the State plan shall comply with the following:

(A) COVERAGE.—With respect to coverage, the State plan shall—

(i) provide and describe the manner in which the State will ensure that an increased number of individuals residing within the State will have expanded access to health care coverage with a specific 5-year target for reduction in the number of uninsured individuals through either private or public program expansion, or both, in accordance with the options established by the Commission;

(ii) describe the number and percentage of current uninsured individuals who will achieve coverage under the State health program;

(iii) describe the minimum benefits package that will be provided to all classes of beneficiaries under the State health program;

(iv) identify Federal, State, or local and private programs that currently provide health care services in the State and describe how such programs could be coordinated with the State health program, to the extent practicable; and

(v) provide for improvements in the availability of appropriate health care services that will increase access to care in urban, rural, and frontier areas of the State with medically underserved populations or where there is an inadequate supply of health care providers.

(B) QUALITY.—With respect to quality, the State plan shall—

(i) provide a plan to improve health care quality in the State, including increasing effectiveness, efficiency, timeliness, patient focused, equity while reducing health disparities, and medical errors; and

(ii) contain appropriate results-based quality indicators established by the Commission that will be addressed by the State as well as State-specific quality indicators.

(C) COSTS.—With respect to costs, the State plan shall—

(i) provide that the State will develop and implement systems to improve the efficiency of health care, including a specific 5-year target for reducing administrative costs (including paperwork burdens);

(ii) describe the public and private sector financing to be provided for the State health program;

(iii) estimate the amount of Federal, State, and local expenditures, as well as, the costs to business and individuals under the State health program;

(iv) describe how the State plan will ensure the financial solvency of the State health program; and

(v) provide that the State will prepare and submit to the Secretary and the Commission such reports as the Secretary or Commission may require to carry out program evaluations.

(D) HEALTH INFORMATION TECHNOLOGY.—With respect to health information technology, the State plan shall provide methodology for the appropriate use of health information technology to improve infrastructure, such as improving the availability of evidence-based medical and outcomes data to providers and patients, as well as other health information (such as electronic health records, electronic billing, and electronic prescribing).

(2) TECHNICAL ASSISTANCE.—The Secretary shall, if requested, provide technical assistance to States to assist such States in developing applications and plans under this section, including technical assistance by private sector entities if determined appropriate by the Commission.

(3) INITIAL REVIEW.—With respect to a State application for a grant under subsection (b), the Secretary and the Commission shall complete an initial review of such State application within 60 days of the receipt of such application, analyze the scope of the proposal, and determine whether additional information is needed from the State. The Commission shall advise the State within such period of the need to submit additional information.

(4) FINAL DETERMINATION.—

(A) IN GENERAL.—Not later than 90 days after completion of the initial review under paragraph (3), the Commission shall determine whether to submit a State proposal to Congress for approval.

(B) VOTING.—

(i) IN GENERAL.—The determination to submit a State proposal to Congress under subparagraph (A) shall be approved by ⅔ of the members of the Commission who are eligible to participate in such determination subject to clause (ii).

(ii) ELIGIBILITY.—A member of the Commission shall not participate in a determination under subparagraph (A) if—

(I) in the case of a member who is a Governor, such determination relates to the State of which the member is the Governor; or

(II) in the case of member not described in subclause (I), such determination relates to the geographic area of a State of which such member serves as a State or local official.

(C) SUBMISSION.—Not later than 90 days prior to October 1 of each fiscal year, the Commission shall submit to Congress a list, in the form of a legislative proposal, of the State applications that the Commission recommends for approval under this section.

(D) APPROVAL.—With respect to a fiscal year, a State proposal that has been recommended under subparagraph (B) shall be deemed to be approved, and subject to the availability of appropriations, Federal funds shall be provided to such program, unless a joint resolution has been enacted disapproving such proposal as provided for in

subsection (e). Nothing in the preceding sentence shall be construed to include the approval of State proposals that involve waivers or modifications in applicable Federal law.

(5) PROGRAM OR PROJECT PERIOD.—A State program or project may be approved for a period of 5 years and may be extended for subsequent 5-year periods upon approval by the Commission and the Secretary, based upon achievement of targets, except that a shorter period may be requested by a State and granted by the Secretary.

(e) EXPEDITED CONGRESSIONAL CONSIDERATION.—

(1) INTRODUCTION AND COMMITTEE CONSIDERATION.—

(A) INTRODUCTION.—The legislative proposal submitted pursuant to subsection (d)(4)(B) shall be in the form of a joint resolution (in this subsection referred to as the ''resolution''). Such resolution shall be introduced in the House of Representatives by the Speaker, and in the Senate, by the Majority Leader, immediately upon receipt of the language and shall be referred to the appropriate committee of Congress. If the resolution is not introduced in accordance with the preceding sentence, the resolution may be introduced in either House of Congress by any member thereof.

(B) COMMITTEE CONSIDERATION.—A resolution introduced in the House of Representatives shall be referred to the Committee on Ways and Means of the House of Representatives. A resolution introduced in the Senate shall be referred to the Committee on Finance of the Senate. Not later than 15 calendar days after the introduction of the resolution, the committee of Congress to which the resolution was referred shall report the resolution or a committee amendment thereto. If the committee has not reported such resolution (or an identical resolution) at the end of 15 calendar days after its introduction or at the end of the first day after there has been reported to the House involved a resolution, whichever is earlier, such committee shall be deemed to be discharged from further consideration of such reform bill and such reform bill shall be placed on the appropriate calendar of the House involved.

(2) EXPEDITED PROCEDURE.—

(A) CONSIDERATION.—Not later than 5 days after the date on which a committee has been discharged from consideration of a resolution, the Speaker of the House of Representatives, or the Speaker's designee, or the Majority Leader of the Senate, or the Leader's designee, shall move to proceed to the consideration of the committee amendment to the resolution, and if there is no such amendment, to the resolution. It shall also be in order for any member of the House of Representatives or the Senate, respectively, to move to proceed to the consideration of the resolution at any time after the conclusion of such 5-day period. All points of order against the resolution (and against consideration of the resolution) are waived. A motion to proceed to the consideration of the resolution is highly privileged in the House of Representatives and is privileged in the Senate and is not debatable. The motion is not subject to amendment, to a motion to postpone consideration of the resolution, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or not agreed to shall not be in order. If the motion to proceed is agreed to, the House of Representatives or the Senate, as the case may be, shall immediately proceed to consideration of the resolution without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the House of Representatives or the Senate, as the case may be, until disposed of.

(B) CONSIDERATION BY OTHER HOUSE.—If, before the passage by one House of the resolution that was introduced in such House, such House receives from the other House a resolution as passed by such other House—

(i) the resolution of the other House shall not be referred to a committee and may only be considered for final passage in the House that receives it under clause (iii);

(ii) the procedure in the House in receipt of the resolution of the other House, with respect to the resolution that was introduced in the House in receipt of the resolution of the other House, shall be the same as if no resolution had been received from the other House; and

(iii) notwithstanding clause (ii), the vote on final passage shall be on the reform bill of the other House.

Upon disposition of a resolution that is received by one House from the other House, it shall no longer be in order to consider the resolution bill that was introduced in the receiving House.

(C) CONSIDERATION IN CONFERENCE.—Immediately upon a final passage of the resolution that results in a disagreement between the two Houses of Congress with respect to the resolution, conferees shall be appointed and a conference convened. Not later than 10 days after the date on which conferees are appointed, the conferees shall file a report with the House of Representatives and the Senate resolving the differences between the Houses on the resolution. Notwithstanding any other rule of the House of Representatives or the Senate, it shall be in order to immediately consider a report of a committee of conference on the resolution filed in accordance with this subclause. Debate in the House of Representatives and the Senate on the conference report shall be limited to 10 hours, equally divided and controlled by the Speaker of the House of Representatives and the Minority Leader of the House of Representatives or their designees and the Majority and Minority Leaders of the Senate or their designees. A vote on final passage of the conference report shall occur immediately at the conclusion or yielding back of all time for debate on the conference report.

(3) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection is enacted by Congress—

(A) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a resolution, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(4) LIMITATION.—The amount of Federal funds provided with respect to any State proposal that is deemed approved under subsection (d)(3) shall not exceed the cost provided for such proposals within the concurrent resolution on the budget as enacted by Congress for the fiscal year involved.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide a grant to a State that has an application approved under subsection (b) to enable such State to carry out an innovative State health program in the State.

(2) AMOUNT OF GRANT.—The amount of a grant provided to a State under paragraph (1) shall be determined based upon the recommendations of the Commission, subject to the amount appropriated under subsection (k).

(3) PERFORMANCE-BASED FUNDING ALLOCATION AND PRIORITIZATION.—In awarding grants under paragraph (1), the Secretary shall—

(A) fund a diversity of approaches as provided for by the Commission in subsection (c)(1)(B);

(B) give priority to those State programs that the Commission determines have the greatest opportunity to succeed in providing expanded health insurance coverage and in providing children, youth, and other vulnerable populations with improved access to health care items and services; and

(C) link allocations to the State to the meeting of the goals and performance measures relating to health care coverage, quality, and health care costs established under this Act through the State project application process.

(4) MAINTENANCE OF EFFORT.—A State, in utilizing the proceeds of a grant received under paragraph (1), shall maintain the expenditures of the State for health care coverage purposes for the support of direct health care delivery at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received.

(5) REPORT.—At the end of the 5-year period beginning on the date on which the Secretary awards the first grant under paragraph (1), the State Health Innovation Advisory Commission established under subsection (c) shall prepare and submit to the appropriate committees of Congress, a report on the progress made by States receiving grants under paragraph (1) in meeting the goals of expanded coverage, improved quality, and cost containment through performance measures established during the 5-year period of the grant. Such report shall contain the recommendation of the Commission concerning any future action that Congress should take concerning health care reform, including whether or not to extend the program established under this subsection.

(g) MONITORING AND EVALUATION.—

(1) ANNUAL REPORTS AND PARTICIPATION BY STATES.—Each State that has received a program approval shall—

(A) submit to the Commission an annual report based on the period representing the respective State's fiscal year, detailing compliance with the requirements established by the Commission and the Secretary in the approval and in this section; and

(B) participate in the annual meeting under subsection (c)(4)(B).

(2) EVALUATIONS BY COMMISSION.—The Commission, in consultation with a qualified and independent organization such as the Institute of Medicine, shall prepare and submit to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce, the Committee on Education and the Workforce, and the Committee on Ways and Means of the House of Representatives annual reports that shall contain—

(A) a description of the effects of the reforms undertaken in States receiving approvals under this section;

(B) a description of the recommendations of the Commission and actions taken based on these recommendations;

(C) an evaluation of the effectiveness of such reforms in—

(i) expanding health care coverage for State residents;

(ii) improving the quality of health care provided in the States; and

(iii) reducing or containing health care costs in the States;

(D) recommendations regarding the advisability of increasing Federal financial assistance for State ongoing or future health program initiatives, including the amount and source of such assistance; and

(E) as required by the Commission or the Secretary under subsection (f)(5), a periodic, independent evaluation of the program.

(h) NONCOMPLIANCE.—

(1) CORRECTIVE ACTION PLANS.—If a State is not in compliance with a requirements of this section, the Secretary shall develop a corrective action plan for such State.

(2) TERMINATION.—For good cause and in consultation with the Commission, the Secretary may revoke any program granted under this section. Such decisions shall be subject to a petition for reconsideration and appeal pursuant to regulations established by the Secretary.

(i) RELATIONSHIP TO FEDERAL PROGRAMS.—

(1) IN GENERAL.—Nothing in this Act, or in section 1115 of the Social Security Act (42 U.S.C. 1315) shall be construed as authorizing the Secretary, the Commission, a State, or any other person or entity to alter or affect in any way the provisions of title XIX of such Act (42 U.S.C. 1396 et seq.) or the regulations implementing such title.

(2) MAINTENANCE OF EFFORT.—No payment may be made under this section if the State adopts criteria for benefits, income, and resource standards and methodologies for purposes of determining an individual's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of the date of enactment of this Act.

(j) MISCELLANEOUS PROVISIONS.—

(1) APPLICATION OF CERTAIN REQUIREMENTS.—

(A) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—

(i) IN GENERAL.—Subject to subparagraph (B), a State shall not permit the imposition of any preexisting condition exclusion for covered benefits under a program or project under this section.

(ii) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—If the State program or project provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the program or project may permit the imposition of a preexisting condition exclusion but only insofar and to the extent that such exclusion is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

(B) COMPLIANCE WITH OTHER REQUIREMENTS.—Coverage offered under the program or project shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

(2) PREVENTION OF DUPLICATIVE PAYMENTS.—

(A) OTHER HEALTH PLANS.—No payment shall be made to a State under this section for expenditures for health assistance provided for an individual to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided health assistance under the plan.

(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—Except as provided in any other provision of law, no payment shall be made to a State under this section for expenditures for health assistance provided for an individual to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) of the Social Security Act shall apply.

(3) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of the Social Security Act shall apply to States under this section in the same manner as they apply to a State under such title XIX:

(A) TITLE XIX PROVISIONS.—

(i) Section 1902(a)(4)(C) (relating to conflict of interest standards).

(ii) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

(iii) Section 1903(w) (relating to limitations on provider taxes and donations).

(iv) Section 1920A (relating to presumptive eligibility for children).

(B) TITLE XI PROVISIONS.—

(i) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

(ii) Section 1124 (relating to disclosure of ownership and related information).

(iii) Section 1126 (relating to disclosure of information about certain convicted individuals).

(iv) Section 1128A (relating to civil monetary penalties).

(v) Section 1128B(d) (relating to criminal penalties for certain additional charges).

(vi) Section 1132 (relating to periods within which claims must be filed).

(4) RELATION TO OTHER LAWS.—

(A) HIPAA.—Health benefits coverage provided under a State program or project under this section shall be treated as creditable coverage for purposes of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

(B) ERISA.—Nothing in this section shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to a group health plan (as defined in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1))).

(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary in each fiscal year. Amounts appropriated for a fiscal year under this subsection and not expended may be used in subsequent fiscal years to carry out this section.

Mr. BINGAMAN. I am pleased to announce today the introduction of bipartisan legislation with Senator VOINOVICH entitled the ''Health Partnership Act of 2006'' with additional bipartisan support from Senators DEWINE and AKAKA. The ''Health Partnership Act'' is intended to move beyond the political gridlock in Washington, D.C., and set us on a path toward finding solutions to affordable, quality health care for all Americans by creating partnerships between the federal government, state and local governments, private payers, and health care providers to implement different and promising approaches to health care.

Federal funding and support would be committed to states to reduce the number of uninsured, reduce costs, and improve the quality of health care for all Americans. Should a state decline to apply or if a unique need exists, local governments also would be authorized to apply for a federal grant for such purposes.

States, local governments, and tribes and tribal governments would be able to submit applications to the federal government for funding to implement a state health care expansion and improvement program to a bipartisan ''State Health Innovation Commission.'' Based on funding available through the federal budget process, the Commission would approve a variety of reform options and innovative approaches.

This federalist approach to health reform would encourage a broad array of reform options that would be closely monitored to see what is working and what is not. As Supreme Court Justice Louis D. Brandeis wrote in 1932, ''It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.''

Our bipartisan legislation, the ''Health Partnership Act,'' encourages this type of state-based innovation and will help the nation better address both the policy and the politics of health care reform. We do not have consensus at the federal level on anyone approach and so encouraging states to adopt a variety of approaches will help us all better understand what may or may not work. And, it is well past the time when we need action to be taking place to address the growing and related problems of the uninsured and increasing health care costs.

In fact, spending on health care in our country has now reached $2 trillion annually, and yet, the number of uninsured has increased to 46 million people, which is six million more than in 2000. The consequences are staggering, as uninsured citizens get about half the medical care they need compared to those with health insurance and, according to the Institute of Medicine, about 18,000 unnecessary deaths occur each year in the United States because of lack of health Insurance.

While gridlock absent a solution continues to permeate Washington, DC, a number of states and local governments are moving ahead with health reform. The premise on which this bill is based is that the federal government should provide support for such efforts rather than constantly undermining them.

The ''Health Partnership Act'' would provide such support, as it authorizes grants to states, groups of states, local governments, and Indian tribes and organizations to carry out any of a broad range of strategies to reach the goals

of reducing the number of uninsured, reducing costs, and improving the quality of care.

As usual, state and local governments are not waiting around for federal action. This is exactly what was happening in the early 1990s as states such as New Mexico, Massachusetts, Pennsylvania, Florida, Rhode Island, Hawaii, Maryland, Tennessee, Vermont, and Washington led the way to expanding coverage to children through the enactment of a variety of health reforms. Some of these programs worked better than others and the federal government responded in 1997 with passage of the ''State Children's Health Insurance Program'' or SCHIP. This legislation received broad bipartisan support and was built upon the experience of the state expansions. SCHIP continues to be a state-based model that covers millions of children and continues to have broad-based bipartisan support across this nation.

So, why not use that successful model and build upon it? In fact, state and local governments are already taking up that challenge and the federal government should, through the enactment of the ''Health Partnership Act,'' do what it can to be helpful with those efforts. For example—

On November 15, 2005, Illinois Governor Rod Blagojevich signed into law the ''Covering All Kids Health Insurance Act'' which, beginning in July 2006, will attempt to make insurance coverage available to all uninsured children.

In Massachusetts, Governor Mitt Romney recently signed into law legislation that requires all Bay State residents to have health insurance. Virtually everyone interested in solutions to our nation's health care problems are looking at the Massachusetts ''experiment'' as a possible solution.

Other states, including New Mexico, Maine, West Virginia, Oklahoma, and New York have enacted other health reforms that have had mixed success.

All of these efforts are very important to add to our knowledge base, which can then lead to the formation of a possible national solution to our uninsured and affordability crisis. We can learn from each and every one of these efforts, whether successful or failed.

Commonwealth Fund President Karen Davis said it well by noting that state-based reforms, such as that passed in Massachusetts, are very good news. As she notes, ''First, any substantive effort to expand access to coverage is worthwhile, given the growing number of uninsured in this country and the large body of evidence showing the dangerous health implications of lacking coverage.''

She adds, ''But something more important is at work here, While we urgently need a national solution so that all Americans have insurance, it doesn't appear that we'll be getting one at the federal level any time soon. So what Massachusetts has done potentially holds lessons for every state.'' I would add that it holds lessons for the federal government as well and not just for the mechanics of implementing health reform policy but also to the politics of health reform.

As she concludes, ''One particularly cogent lesson is the manner in which the measure was crafted—via a civil process that successfully brought together numerous players from across the political business, health care delivery, and policy sectors.''

Mr. President, Senator VOINOVICH and I have worked together for many months now on this legislation via a process much like that described by Karen Davis. The legislation stems from past legislative efforts by senators such as Bob Graham, Mark Hatfield, and Paul Wellstone, but also from work across ideological lines by Henry Aaron of the Brookings Institute and Stuart Butler of the Heritage Foundation.

The legislation also received much advice and support from Dr. Tim Garson who, as Dean of the University of Virginia, brought a much needed provider perspective which is reflected in support for the legislation from the American Medical Association, the American Academy of Pediatrics, the American College of Physicians, the American College of Cardiology, American Gastroenterological Association, the Visiting Nurses Association, the National Association of Community Health Centers, and from state-based health providers such as the New Mexico Medical Society and Ohio Association of Community Health Centers.

And the legislation also received much comment and support from consumer-based groups advocating for national health reform, including that by Dr. Ken Frisof and UHCAN, which is the Universal Health Care Action Network, Bill Vaughan at Consumers Union, and from numerous health care advocates in New Mexico, including Community Action New Mexico, Health Action New Mexico, Health Care for All Campaign of New Mexico, New Mexico Center on Law and Poverty, New Mexico Health Choices Initiative, New Mexico POZ Coalition, New Mexico Public Health Association, New Mexico Religious Coalition for Reproductive Choice, New Mexico Progressive Alliance for Community Empowerment, and the Health Security for New Mexicans Campaign, which includes 115 organizations based in the State.

Support from all stakeholders in our nation's health care system has been sought and I would like to thank the many organizations from New Mexico for their support and input to this legislation. There is great urgency in New Mexico because our State, like all of those along the U.S.-Mexico border, faces a severe health care crisis. In fact, New Mexico ranks second only to Texas in the percentage of its citizens who are uninsured. New Mexico is also the only state in the country with less than half of its population having private health insurance coverage.

A rather shocking statistic, which also continues to worsen, is that one out of every three Hispanic citizens are uninsured. In fact, less than 43 percent of the Hispanic population now has employer-based coverage nationwide, which is in sharp comparison to the 68 percent of non-Hispanic whites who have employer-based coverage.

The State has also enacted its own health reform plan called the State Coverage Initiative, or SCI in July 2005. SCI is a public/private partnership that is intended to expand employer-sponsored insurance and was developed in part with grant funding from the Robert Wood Johnson Foundation. As of May 1, there were just over 4,500 people covered by this initiative and there are efforts to expand this effort to cover over 20,000 individuals. With federal support for my State, the hope would be to further expand coverage to as many New Mexicans as possible.

It is also important to note that the legislation encourages reforms at both the state and local levels of government. Senator VOINOVICH, as former Mayor of Cleveland, suggested language that would capture community-based efforts as well. Illinois, Georgia, Michigan, and Oregon have all initiated efforts at the local level for reform, including what is known as the ''three-share'' programs in Illinois and Michigan. These initiatives have employers, employees, and the community each pick up about one-third of the cost of the program.

Jeaneane Smith, deputy administrator in the Office of Oregon Health Policy and Research was quoted in a recent Academy Health publication saying, ''In recent years it has become apparent that there is a need to consider both state- and community-level approaches to improved access. We want to learn how best to support communities as they play an integral part in addressing the gaps in coverage.''

Our hope is to spawn as much creative innovation as possible. Brookings Institute Senior Health Fellow Henry Aaron and Heritage Foundation Vice President Stuart Butler wrote a Health Affairs article in March 2004 that lays out the foundation for this legislative effort. They argue that while we remain unable to reconcile how best to expand coverage at the federal level, we can agree to support states in their efforts to try widely differing solutions to health coverage, cost containment, and quality improvement. As they write, ''This approach offers both a way to improve knowledge about how to reform health care and a practical way to initiate a process of reform. Such a pluralist approach respects the real, abiding differences in politics, preferences, traditions, and institutions across the nation. It also implies a willingness to accept differences over an extended period in order to make progress. And it recognizes that permitting wide diversity can foster consensus by revealing the strengths and exposing the weaknesses of rival approaches.''

The most important message that I hope this bill carries is that we must stop having the perfect be the enemy of the good. This proposal is certainly not perfect but we hope it makes a very

important contribution to addressing our nation's health care crisis.

In addition to Dr. Garson, Mr. Aaron, Mr. Butler, and Dr. Frisof, I would like to express my appreciation to Dan Hawkins at the National Association of Community Health Centers, Bill Vaughan at Consumers Union, and both Jack Meyer and Stan Dorn at ESRI for their counsel and guidance on health reform and this legislation.

I would also like to commend the American College of Physicians, or ACP, for their outstanding leadership on the issue of the uninsured and for their willingness to support a variety of efforts to expand health coverage. ACP has been a longstanding advocate for expanding health coverage and has authored landmark reports on the important role that health insurance has in reducing people's morbidity and mortality. In fact, to cite the conclusion of one of those studies, ''Lack of insurance contributes to the endangerment of the health of each uninsured American as well as the collective health of the nation.''

And finally, I would also thank the many people at the Robert Wood Johnson Foundation on their forethought and knowledge on all the issues confronting the uninsured. Their efforts to maintain the focus and dialogue on addressing the uninsured has kept the issue alive for many years.

I hope we can break the gridlock and urge my colleagues to support this important legislation.

I would ask for unanimous consent for a Fact Sheet and copy of the Health Affairs article entitled ''How Federalism Could Spur Bipartisan Action on the Uninsured'' be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE HEALTH PARTNERSHIP ACT

Introduced by Senators Voinovich and Bingaman in May 2006—''A bill to provide for innovation in health care through state initiatives that expand coverage and access and improve quality and efficiency in the health care system.''

The Health Partnership Act, cosponsored by U.S. Senators Voinovich (R–OH) and Bingaman (D–NM), is a first step to move beyond the political deadlock that has prevented the United States from finding paths to affordable, quality health care for all. For decades, national solutions have proven impossible to attain because of sharp differences on how to pay for and organize health care services. The Health Partnership Act breaks through the impasse. It creates partnerships among the federal government, state governments, private payers and health care providers to implement different approaches to achieve sustainable reform that provides affordable, quality health care for all. It demonstrates federal leadership on health care through establishing a mechanism by which federal dollars are committed to states to reduce the number of uninsured and to improve the quality of health care for all.

A creative new bipartisan initiative to move beyond political deadlock and a potential first step towards affordable quality health care for all.

THE FEDERAL LEVEL

Federal dollars will fund five-year State Health Care Expansion and Improvement Grants. The amount of federal funding for new grants will be determined annually in the budgetary process.

The bill establishes a bipartisan State Health Innovation Commission composed of national, state and local leaders that will:

Issue requests for proposals.

Establish, in collaboration with an organization such as the Institute of Medicine, minimum performance standards and 5-year goals.

Provide states with a ''toolkit'' of reform options, such as single-payer systems, public program expansions, pay-or-play mechanisms, tax credit incentives, health savings accounts, etc.

Ensure the maintenance of Medicaid—prohibiting restrictive rule changes that would limit eligibility or benefits.

Recommend to Congress which grants to support, giving preference to states maximizing the reduction in numbers of the uninsured.

Monitor the progress of programs and promote information exchange on what works.

Recommend ways to minimize negative effects on national employer groups, providers and insurers related to differing state requirements.

STATE LEVEL

Each state applying for a grant will develop a health care plan to increase coverage, improve quality and reduce costs, with specific targets for reduction in the number of uninsured and the costs of administration.

States will receive renewable grants for five-year expansion and improvement programs.

States will receive from the federal level technical assistance, if requested, for developing proposals.

Each state plan would address:

Coverage by describing the process and setting a 5-year target for reducing the number of uninsured individuals in the state.

Quality by providing a plan to increase health care effectiveness, efficiency, timeliness, and equity while reducing health disparities and medical errors.

Costs by developing and implementing systems to improve the efficiency of health care, including a 5-year target to reduce administrative costs and paperwork burdens.

Information technology by designing the appropriate use of health information technology to improve infrastructure, to expand the availability of evidence-based medical and to provide outcomes data to providers and patients.

STATES IN THE LEAD: LESSONS ON THE PROCESS OF MAKING CHANGE

Given the inaction of the federal government on health care access issues, states have begun to address these challenges creatively with sensitivity to local ideas and conditions. Dozens of states are considering new proposals. Five have already acted.

Maine, June 2003—the Dirigo Health Plan.

California, October 2003—phased-in Employer Mandate (repealed by ballot initiative, November 2004).

Illinois, September 2005—Health Care for All Children.

Maryland, January 2006—Fair Share Health Care (employer mandate for the largest employers).

Massachusetts, April 2006—Massachusetts Health Reform Package—with both an individual and an employer mandate.

The recently passed Massachusetts law deserves special attention because it is the first one enacted cooperatively with a divided government—a strongly Democratic state legislature and a Republican governor.

The detailed policy particulars in each of these state measures are controversial, with strong supporters and strong detractors. But they teach us a lot about the process of reforming health care in America.

State political leadership at the highest level is necessary.

Active consumer advocacy plays an important role.

Some stakeholder leadership must be willing to put the larger public interest above their own narrow economic self-interest.

The proposals have implementation phased in over several years.

It is easier for these proposals to expand access than to restrain the growth of costs—the latter being critical to make them sustainable over the long term.

Massachusetts, in particular, demonstrated how modest federal financial incentives (in this case the threatened loss of less than 1/10 of federal Medicaid funding) can provide the critical stimulus for leaders to come together to create comprehensive reform.

POLITICAL ADVANTAGES OF THE HEALTH PARTNERSHIP ACT

The Health Partnership Act provides positive multi-year financial incentives to states to address these issues, making it more likely for them to take the first steps and less likely to backslide when money concerns arise.

Congress need not pick just one path to health care for all. Members may be willing to let other states try models that they would oppose in their home states.

Allowing states to design their own plans, based on simple federal standards, has the potential to break through the current political deadlock. Breakthroughs in some states could be replicated elsewhere.

Advocacy is needed concurrently at the state and federal levels, with each reinforcing the other.

Federal support has the potential to counteract likely opposition by special interests in state efforts.

POLICY ADVANTAGES OF THE HEALTH PARTNERSHIP ACT

The process of implementing a variety of partnerships recognizes that one national plan may not address the differences among states and encourages states to address creatively their own needs.

Lessons learned in testing diverse state plans would benefit other states and national reform.

HOW FEDERALISM COULD SPUR BIPARTISAN ACTION ON THE UNINSURED

(By Henry J. Aaron and Stuart M. Butler)

Nearly everyone thinks that something should be done to reduce the number of Americans lacking health insurance. Unfortunately, while numerous plans exist on how to reach that goal, few agree on any one. In deed, as authors we disagree on how best to extend and assure health insurance coverage. Nonetheless, we believe that using the pluralism and creative power of federalism is the best way to break the political logjam and to discover the best way to expand coverage.

Accordingly, we believe that states should be strongly encouraged to try any of a wide range of approaches to increasing health insurance coverage and rewarded for their success. This approach offers both a way to improve knowledge about how to reform health care and a practical way to initiate a process of reform. Such a pluralist approach respects the real, abiding differences in politics, preferences, traditions, and institutions across

the nation. It also implies a willingness to accept differences over an extended period in order to make progress. And it recognizes that permitting wide diversity can foster consensus by revealing the strengths and exposing the weaknesses of rival approaches.

Despite our abiding disagreements on which substantive approach to extending coverage is best, we believe that people of goodwill must be prepared to countenance the testing of ideas they oppose if progress is to be made. Moreover, we believe that there is no hope for legislation to begin to transform the largest U.S. industry—health care—unless such legislation enjoys strong support from both major political parties.

USING FEDERALISM TO SPUR ACTION

Proposals to reduce the number of uninsured Americans abound. Some favor expanding government programs, such as Medicaid. Others favor refundable tax credits to help families buy private health insurance. Still others favor regulatory approaches, such as changes in insurance rules. But working together in health care to achieve a goal shared by virtually everyone has proved to be impossible. One reason for this is that the capacity to reach substantive compromise in Washington has seriously eroded. Among the causes is the widespread view that reforming the complex health care system requires very carefully designed and internally consistent actions. Some say that it is like building a new airplane: Unless all the key parts are there and fit together perfectly, the airplane will not fly. Thus, many proponents of particular approaches fear that abandoning key components of their proposals to achieve a compromise will prevent a fair test of their favored approach and lead to failure. Another obstacle is that many lawmakers believe that approaches that might conceivably work in one part of the country, given the cultural, philosophical, or health industry conditions prevailing there, will not work in their state or district because of different local conditions. This view leads many in Congress to resist proposals that might work in some areas because they believe that those proposals could make things worse for their constituents.

These and other factors have stalled efforts to extend health insurance and achieve other reforms for decades. The enactment of Medicare and Medicaid stands as one notable—and instructive—exception to that pattern. Medicare sprang from comprehensive social insurance initiatives of congressional Democrats, Medicaid from limited needs based approaches of congressional Republicans. The passage of each program was possible only because the two initiatives were linked in the form of a trade-off, not so much by blending some elements of each approach but by moving forward with two programs in parallel: Medicare for the elderly and disabled, and Medicaid for the poor of all ages. That experience illustrates a principle of politics: that progress often requires combining elements of competing proposals into a hybrid legislative initiative, in which internally consistent approaches operate in parallel.

In our view, federalism offers a promising approach to the challenge of building support to tackle the problem of uninsurance. While proponents of nationwide measures to introduce health insurance tax credits, or to extend Medicare or the State Children's Health Insurance Program (SCHIP) to other groups, should of course continue to make their case for national policies, we emphasize an initiative designed to support states in launching a variety of localized initiatives. Under this process, the federal government would reward states that agreed to test comprehensive and internally consistent strategies that succeeded in extending coverage within their borders. In contrast to block grants, federal-state covenants would operate within congressionally specified policy constraints designed to achieve national goals for extending health insurance. These covenants would include plans ranging from heavy government regulation to almost none, as long as the plans were consistent with the broad goals and included specified protections. States could also select items from a federally designed ''policy toolbox'' to include in their proposals. Allowable state plans would include forms of single-payer plans, employer mandates, mandatory individual purchase of privately offered insurance, tax credits, and creative new approaches. States would be free not to undertake such experiments and continue with the current array of programs, but sizable financial incentives would be offered to those that chose to experiment and financial rewards given to those that achieve agreed-upon goals.

The model we propose builds upon proposals we have outlined elsewhere. It is also compatible with some other federalism approaches, such as the plan advanced by the Institute of Medicine. We favor a wide diversity of federal-state initiatives for three reasons. First, fostering a bold program in a state will produce much information that will aid the policy discovery process. Successes will encourage others to follow, while unanticipated problems will force redesign or abandonment and will be geographically contained. Second, encouraging bold state action will quickly and directly extend coverage to many of the uninsured. Instead of facing continued national inaction or the potential for disruption of state initiatives by future federal action, states would have the incentive and freedom to act decisively. Third, we see no evidence of an emerging consensus on how to deal with these problems at the national level. But our proposal is based on the observation that advocates of rival plans trust their preferred approaches enough to believe that a real-life version would persuade opponents and create a consensus. Not all can be right, of course, but all advocates of health insurance reform, like residents of Lake Wobegon, seem to believe that their plans are above average. Thus, they should be open to the idea of testing diverse proposals. Our proposal is a process to enable policymakers to discover which is right, either for the whole country or for a region.

CORE ELEMENTS

We propose that Congress provide financial assistance and a legal framework to trigger a diverse set of federal-state initiatives. To help break the impasse in Congress over most national approaches, we propose steps designed to enable ''first choice'' political ideas to be tried in limited areas, with the support of states and through the enactment of a federal ''policy toolbox'' of legislated approaches that would be available to states but not imposed on them. Our view is that elected officials would be prepared to authorize some approaches now bottled up in Congress if they knew that the approach would not be imposed on their states. Our proposed strategy would contain six key elements.

Goals and protections. First, Congress would set certain goals and general protections. Goals would be established for extending coverage, and perhaps improving the coverage of some of those with inadequate coverage today. One such goal could be a percentage reduction in the number of uninsured people in a state. The more precise the goals, the more contentious they are likely to be. But clear and measurable goals under the proposed covenants are necessary if the system of financial rewards described below is to work effectively.

What is ''insurance''? For a coverage goal to mean anything, it would have to define what constitutes ''insurance.'' Specifying adequate coverage in health care is no easier than quantifying an adequate high school education, and when money follows success, drafting such definitions becomes even more difficult.

In defining what is meant by adequate insurance, agreement on two characteristics is vital: the services to be covered and the maximum residual costs (deductibles and copayments) that the insured must bear. States could be more generous than these standards. Instead of speciying precisely what states must do in each of these dimensions, we suggest that Congress establish a required actuarial minimum—such as the cost of providing the benefit package of the Federal Employees Health Benefits Program (FEHBP) for the state's population—as the standard, with states retaining considerable latitude on which services to include and how much cost sharing to require. Whether to set this actuarial standard high or low will be controversial and will determine the overall cost to the federal government of eliciting state participation.

Both high and low benefit standards suffer from well-known problems. High standards would raise program costs and weaken individuals' incentives to be prudent purchasers of health care. Low standards expose patients to sizable financial risk and raise questions about whether to restrict patients' right to buy supplemental coverage. Thus, federal legislation would not specify the content of insurance plans beyond some such actuarial amount. States would then be free to design plans as they wish, although certain types of plans might be presumptively acceptable (see below), and others could be negotiated as part of a covenant. The exact mix of benefits could vary within reason, but no further limits would be imposed. One goal of this approach, after all, is to encourage experimentation to generate information on whether particular configurations of benefits work better than others. It might turn out, for example, that states would adopt quite different plans with similar actuarial values. One group might opt for high deductible plans covering a wide range of services with no cost sharing above the deductible and generous relief from the deductible for the poor, while others might adopt a system with low deductibles and modest cost sharing but covering a much narrower range of benefits. Discovering how individuals' and providers' attitudes and behavior differ under such plans and how health outcomes vary would provide valuable information for private health insurance planners and government officials.

Protections for individuals. In addition to the definitional question, the question also arises, What limitations and protections should be applied to state experiments? If a simple net reduction in uninsurance guaranteed a financial reward to a state, for example, the state would have the incentive to drop coverage of costly high-risk adults and extend coverage to less costly (healthier and younger) workers. Some such concerns could be addressed in negotiating covenants, but some broad protections and policy ''corridors'' would be established under our proposal and would be necessary to achieve political support.

One of the most politically sensitive would be a primum non nocere limitation. That is, states could not introduce a plan that reduced coverage for currently insured populations, most notably the Medicaid population, beyond some minimum amount. We believe that no reform proposal is likely to

be achievable without that restriction. Most Medicaid outlays in many states are not strictly mandated by federal law, in the sense that some beneficiaries and some services for all beneficiaries are optional. States provide optional coverage because federal law permits it, and the federal match makes its provision attractive to states. If incentives were introduced to cover the non-Medicaid population, states might find it financially and politically attractive to increase the total number of insured people by curtailing Medicaid eligibility and benefits and using the money saved, together with federal support, to cover a larger number of people who are uninsured but less poor.

Designing and enforcing rules to prohibit or limit such ''insurance swapping'' would be extremely challenging but politically—and, one could argue, morally—essential. On the other hand, we believe that states should have some opportunity to propose different ways of delivering the Medicaid commitment to the currently insured population, as long as the degree and quality of coverage were not diminished. That form of Medicaid protection could stimulate creativity and improvement in coverage for the poorest citizens while avoiding any threat to their existing coverage. To be sure, there are disagreements, including between us, on the degree of freedom states should have in deciding how to deliver the Medicaid commitment. Positions range from only minor tweaking to sweeping changes in the delivery system, such as allowing states to use Medicaid money to subsidize individual enrollment in an equivalent private plan. The degree of flexibility states should have, while maintaining eligibility and level of coverage, is a difficult political issue for Congress to decide.

Acceptable state proposals would also have to limit cost sharing and features analogous to pension nondiscrimination rules. We believe that requirements, consistent with the general goals and protections we propose, are needed to ensure that lower-income households do not face unaffordable coverage. Without such limits, states could reduce the number of uninsured people and secure attendant federal financial support, for example, by instituting an individual mandate with a high premium that would effectively make insurance universal among the financially secure and do little for the poor. States would need to propose a fair, plausible way of meeting the requirement, such as by mandating some form of community rating or through a cross-subsidy to more vulnerable populations.

The federal government should establish broad guidelines, but no more. A key principle of our proposal is that state officials are more likely than federal officials to design successful solutions to those problems that members of the policy or congressional staff community have failed to solve. Congress can and should set the parameters, but it should avoid micromanagement.

''Policy toolbox'' of federal policies and programs. A feature of the congressional impasse noted earlier is that many plausible health initiatives that might merit testing, and have support in some states, are blocked by other lawmakers who oppose the introduction of the approach in their own state or across the country. Thus, we propose that Congress enact presumptively legitimate approaches to the expansion of health insurance coverage as a ''policy toolbox'' that would be available to states a la carte to apply within their borders. Lawmakers could safely vote to permit an initiative, confident that it would not be imposed on their states. In this way, potentially useful policies and programs could be ''unlocked'' from Congress and become available for states to use in their own initiatives.

A policy toolbox likely would include expansions of existing policies, such as raising income limits under Medicaid or lowering the age of Medicare eligibility. It could include arrangements to subsidize individual buy-ins to the FEHBP, refundable tax credits or their equivalent (perhaps with some steps to modify the federal income tax exclusion for employee-sponsored health insurance costs), mandating employer or individual coverage, or creating a single state insurance plan though which everyone may buy subsidized coverage.

Other possible examples might include the following: (1) Remove regulatory and tax obstacles to churches, unions, and other organizations providing group health insurance plans. This could open up new forms of group coverage offered though organizations with an established membership and common values. (2) Allow Medicaid and SCHIP to cover additional populations, with greatly enhanced federal matching payments, and perhaps to operate in very different ways—with appropriate safeguards to protect those who are covered under current law. Both federal welfare legislation and SCHIP, for example, included safeguards to preserve existing Medicaid coverage. (3) Extend limited federal Employee Retirement Income Security Act (ERISA) protection to large corporate health plans willing to enroll nonemployees, and extend the tax exclusion to those enrollees. This could lead in a state to expanded access to comprehensive coverage. (4) Provide a voucher to individuals designed to mimic a comprehensive refundable tax credit for health insurance. This could allow the practical issues of a major tax credit approach to be examined. (5) Enact legislation to make forms of FEHBP-style coverage available to broader populations within states. This would enable states and federal government to explore the issues associated with extending the program to nonfederal employees and retirees. (6) Enable states to establish association plans and other innovative health organizations.

We emphasize that any menu of tools would be optional for states. None would be required. Members of Congress would be more likely to agree to the inclusion of elements they would deplore in their own states if they knew that no state, including their own, would be forced to adopt them than they would be in a nationally uniform system. Some lawmakers, for instance, oppose association plans be cause they believe that such plans would disrupt successful state insurance arrangements. Under the menu approach, association plans would be introduced only in states wishing to use them as part of their overall strategy.

State proposals, federal approval. Under our proposed strategy, states interested in a bold, creative initiative would design a proposal consistent with the goals and restrictions established by Congress. Typically this proposal would include some elements from the federal policy toolbox in conjunction with state initiatives.

Needless to say, a critical congressional decision would concern mechanisms for approving state plans and monitoring state performance. States would no doubt seek to take advantage of every financial opportunity to game the system and to stretch agreements to the limit, as the almost zany history of the Medicaid upper payment level (UPL) controversy makes painfully clear. Yet monitoring state behavior, determining state violations, and enforcing penalties on states is enormously difficult. Moreover, the entity could (and we think should) have the power to negotiate parts of a proposal, not merely approve or reject it, so that refinements could be made consistent with Congress's objectives.

But what entity should this be? It might seem natural to designate an executive agency that reports to the president, such as the Department of Health and Human Services (HHS). We suspect, however, that many members of Congress would refuse to cede so much selection authority to another branch of government and that roughly half would fear partisan decisions by an administration of the ''other'' party. Congress would likely insist on adding suffocating selection criteria and other restrictions to executive department decisions, jeopardizing the very creativity we intend. Thus, we favor instead an existing or newly created body that has independence but ultimately answers to Congress. A new bipartisan body might perform this function with members selected by Congress and the administration or with members also representing the states, with technical advice from the U.S. Government Accountability Office (GAO). This body would evaluate and negotiate draft state proposals according to the general requirements specified by Congress and then present a recommended ''slate'' of proposals to Congress for an up-or-down vote without amendment. Once the state proposals had been selected, HHS would be responsible for implementing the program.

Bipartisan willingness to authorize state programs and to appropriate sufficient funds to elicit state participation also requires that members of Congress believe that approaches they find congenial will receive a fair trial and agree that approaches they reject will also receive a fair trial. Unfortunately, current federal legislation makes two key approaches difficult to implement in individual states or even groups of states: a single-payer plan and an individual mandate combined with refundable tax credits. A federalist approach should include mechanisms that would enable states to give such proposals as fair and complete a test as possible, both because that would provide valuable information and because the political support of their advocates is important in Congress.

Crafting a single-payer experiment. ERISA, which exempts self-insured plans from state regulation, is the primary technical obstacle to testing single-payer plans. The political sensitivity to modifications in ERISA is difficult to exaggerate. Any attempt to carve out an exception from ERISA for state programs to extend cover age would probably doom federal legislation. But states could create ''wrap around'' plans to cover all who are not currently insured, or even to cover all who are not insured under plans exempted by ERISA from state regulation. While such an arrangement would not be a single-payer plan, it could achieve universal coverage, which is one defining characteristic of single-payer plans, and arguably be sufficient for a valid test. After all, the U.S. health care system is characterized by different subsystems for certain populations and has a form of single-payer coverage for military veterans. But of course the real test is whether advocates of single-payer plans regard such a limited arrangement as a fair trial.

An individual tax credit approach. The obstacles to a state level individual mandate with a refundable credit are also serious and complicated. We presume that an individual mandate would require some contribution from people with incomes above defined levels. Such a mandate raises both political and practical questions. Testing federal tax reform in selected geographic areas also raises constitutional and practical issues, although advocates of the approach maintain that other site-specific programs involving federal tax changes, such as enterprise zones,

have passed muster. In addition, for a limited experiment it might be possible to design subsidy programs that would mimic tax relief.

Administering a refundable tax credit would pose formidable difficulties for some states, particularly those that do not have a personal income tax. In all states, the logistics of providing a credit with reasonable accuracy on a timely basis would be challenging. So, too, would deciding how to address such administrative problems as households that live in one state yet work in another. Advocates for tax credits say they have solutions to these and similar challenges, just as supporters of single-payer approaches or employer mandates claim to have answers to challenges facing those approaches. For instance, some maintain that the employment-based tax withholding system could serve as a vehicle for refundable credits or equivalent subsidies and would make individual enrollment practical. Whether or not they are right is of course disputed by their critics. The beauty of a ''put up or shut up'' federalism initiative is that it offers a chance for advocates to offer such solutions in practice instead of in theory.

Using ''managed federalism'' to build support? Deciding how many states could qualify for experiments is an open political and technical question. One approach would be to limit it to a few states. This would limit costs but has little else to be said for it. Accordingly, we would favor opening the program to all states wishing to accept a federal offer. Nevertheless, we recognize that some lawmakers would be reluctant to vote for a process of federal-state innovation unless they were sure that certain ''generic'' or ''standard'' approaches were included—especially if the number of states in the program were to be limited. In particular, we believe that our proposal can win congressional support only if liberals and conservatives alike are fully convinced that the approaches each holds dear will receive a fair and full trial in practice.

While we believe that any state initiative that meets approval should be welcomed, political considerations thus might require that no state's proposal would be approved unless a sufficient range of acceptable variants was proposed. For example, strong advocates of market-based or single-payer approaches might find the federalism option acceptable only if each was confident that favored approaches would be tested.

Adequate data collection. To determine whether a state was actually making progress toward a goal, accurate and timely data would be needed. These data would include surveys of insurance coverage, with sufficient detail to provide state-level estimates. Such surveys would be essential to show whether the states were making progress in extending health insurance coverage. They are vital to the success of the whole approach because payments to states (apart from modest planning assistance) should be based on actual progress in extending coverage, not on compliance with procedural milestones.

Congress should also assure that states report on use of health services, costs, health status, and any other information deemed necessary to judge the relative success of various approaches to extending coverage. Only a national effort could ensure that data are comparable across states. States' cooperation with data collection would be one element of the determination of whether a state was in compliance with its covenant and was therefore eligible for full incentive payments. The experience with state waivers under welfare before enactment of the 1996 welfare reform clearly illustrates the power and importance of such data collection. The cumulative effect of the reports showing the effectiveness of welfare-to-work requirements in reducing rolls, increasing earnings, and raising recipients' satisfaction transformed the political environment and made welfare reform inescapable.

Rewarding progress. Congress would design a formula under which states would be rewarded for their progress in meeting the agreed federal-state goals of extending insurance coverage. As experience with countless grant programs attests, haggling over such formulas can become politics at its grubbiest, with elected officials voting solely on the basis of what a particular formula does for their districts. Even without political parochialism, designing a formula that rewards progress fairly is no easy task. For one thing, states will be starting from quite different places. The proportion of states' uninsured populations under age sixty-five during 1997–1999 ranged from 27.7 percent in New Mexico and 26.8 percent in Texas to 9.6 percent in Rhode Island and 10.5 percent in Minnesota and Hawaii. Designing an incentive formula to reward progress amid such diverse conditions is both an analytical and a political challenge. Moreover, the per capita cost of health care varies across the nation, which further complicates the assessment of progress. The cost of extending coverage depends on the geographic location, income, and health status of the uninsured population. Having financial access may be hollow in communities where services are physically unavailable or highly limited. Extending coverage may require supply-side measures to supplement financial access.

We believe that the only way to design such a formula is to remove the detailed design decisions from congressional micromanagement. We suggest that Congress be asked to adopt the domestic equivalent of ''fast-track'' trade negotiation rules or base-closing legislation. Under this arrangement, Congress would designate a body appointed in equal numbers by the two parties, to design an incentive formula that Congress would agree to vote up or down, without amendments. Such a formula would have to recognize the different positions from which various states would start. Any acceptable formula would have to reward both absolute and relative reductions in the proportions of uninsured people. Whether financial incentives would be offered for other dimensions of performance and how performance would be measured constitute additional important challenges.

Sources of funding. Bleak budget prospects could cause one to give up on this or any other attempt to extend health insurance coverage broadly. But as recent history amply illustrates, the political and budgetary weather can change dramatically and with little notice. What funding approach would be desirable if funds were available? Under our proposal, the federal funding would be intended for several broad purposes: (1) A large portion of the money would be used to help states actually fund approaches to be tested. (2) Some funding (perhaps with assistance from private foundations) would provide national support and technical assistance to states. A model to consider for such support is the Health Resources and Services Administration (HRSA) State Planning Grants program, which both funds state planning activities and provides federal support and technical assistance. (3) Some funds would cover the cost of independent performance monitoring. (4) Some funds would be set aside to reward states for meeting the goals in their agreed-upon plan. Congress might consider an automatic ''performance bonus'' system similar to the mechanism used in welfare reform. Congress could also consider withholding the periodic release of part of a state's grant pending a periodic assessment by the independent monitor of the degree to which the state is accomplishing the objectives specified in its covenant. Only those states willing to offer proposals designed to achieve the national goals would be eligible for a share of the funding or for the menu of federal policy tools. A state could decline to offer a proposal and remain under current programs.

Federalism enables the states to undertake innovative approaches to challenges facing the United States. Federal legislation often grants states broad discretion in designing even those programs for which the federal government bears much or most of the cost. In health care as well as education or welfare, states have been the primary innovators. But the federal government limits, shapes, and facilitates such innovation through regulation, taxation, and grants. Such a partnership is bound to be marked by conflict and tension as state and federal interests diverge.

A creative federalism approach of the kind we propose would change the dynamics of discovering better ways to expand insurance coverage, just as a version of this approach triggered a radical change in the way states addressed welfare dependency. By actually testing competing approaches to reach common goals, rather than endlessly debating them, the United States is far more likely to find the solution to the perplexing and seemingly intractable problem of uninsurance.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 471—RECOGNIZING THAT, DURING NATIONAL FOSTER CARE MONTH, THE LEADERS OF THE FEDERAL, STATE, AND LOCAL GOVERNMENTS SHOULD PROVIDE LEADERSHIP TO IMPROVE THE CARE GIVEN TO CHILDREN IN FOSTER CARE PROGRAMS

Mr. COLEMAN (for himself, Ms. LANDRIEU, and Mr. CRAIG) submitted the following resolution, which was considered and agreed to:

S. Res 471

Whereas more than 500,000 children are in foster care programs throughout the United States;

Whereas, while approximately ¼ of all children in foster care programs are available for adoption, only about 50,000 foster children are adopted each year;

Whereas many of the children in foster care programs have endured—

(1) numerous years in the foster care system; and

(2) frequent moves to and from foster homes;

Whereas approximately 50 percent of foster care children have been placed in foster care programs for longer than 1 year;

Whereas 25 percent of foster care children have been placed in foster care programs for at least 3 years;

Whereas children who spend longer amounts of time in foster care programs often experience worse outcomes than children who are placed for shorter periods of time;

Whereas children who spend time in foster care programs are more likely to—

(1) become teen parents;

(2) rely on public assistance when they become adults; and

(3) interact with the criminal justice system;

Whereas Federal, State, and local governments—

(1) share a unique relationship with foster children; and

(2) have removed children from their homes to better provide for the safety, permanency, and well-being of the children;

Whereas unfortunately, studies indicate that Federal, State, and local governments have not been entirely successful in caring for foster children;

Whereas Congress recognizes the commitment of Federal, State, and local governments to ensure the safety and permanency of children placed in foster care programs; and

Whereas every child deserves a loving family: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes—

(A) May 2006 as ''National Foster Care Month''; and

(B) that, during National Foster Care Month, the leaders of the Federal, State, and local governments should rededicate themselves to provide better care to the foster children of the United States; and

(2) resolves to provide leadership to help identify the role that Federal, State, and local governments should play to ensure that foster children receive appropriate parenting throughout their entire childhood.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3861. Mr. SMITH submitted an amendment intended to be proposed by him to the bill S. 1955, to amend the title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table.

SA 3862. Mr. KERRY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3863. Mr. SMITH submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3864. Mr. SMITH submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3865. Mr. SMITH submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3866. Mr. SMITH submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3867. Ms. SNOWE submitted an amendment intended to be proposed by her to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3868. Mr. OBAMA submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3869. Mr. OBAMA submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3870. Mr. OBAMA submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3871. Mrs. FEINSTEIN (for herself, Mr. DORGAN, Mr. BINGAMAN, and Ms. STABENOW) submitted an amendment intended to be proposed by her to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3872. Mr. KERRY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3873. Mr. LEAHY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3861. Mr. SMITH submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Local Law Enforcement Enhancement Act of 2005''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The incidence of violence motivated by the actual or perceived race, color, religion, national origin, gender, sexual orientation, or disability of the victim poses a serious national problem.

(2) Such violence disrupts the tranquility and safety of communities and is deeply divisive.

(3) State and local authorities are now and will continue to be responsible for prosecuting the overwhelming majority of violent crimes in the United States, including violent crimes motivated by bias. These authorities can carry out their responsibilities more effectively with greater Federal assistance.

(4) Existing Federal law is inadequate to address this problem.

(5) The prominent characteristic of a violent crime motivated by bias is that it devastates not just the actual victim and the family and friends of the victim, but frequently savages the community sharing the traits that caused the victim to be selected.

(6) Such violence substantially affects interstate commerce in many ways, including—

(A) by impeding the movement of members of targeted groups and forcing such members to move across State lines to escape the incidence or risk of such violence; and

(B) by preventing members of targeted groups from purchasing goods and services, obtaining or sustaining employment, or participating in other commercial activity.

(7) Perpetrators cross State lines to commit such violence.

(8) Channels, facilities, and instrumentalities of interstate commerce are used to facilitate the commission of such violence.

(9) Such violence is committed using articles that have traveled in interstate commerce.

(10) For generations, the institutions of slavery and involuntary servitude were defined by the race, color, and ancestry of those held in bondage. Slavery and involuntary servitude were enforced, both prior to and after the adoption of the 13th amendment to the Constitution of the United States, through widespread public and private violence directed at persons because of their race, color, or ancestry, or perceived race, color, or ancestry. Accordingly, eliminating racially motivated violence is an important means of eliminating, to the extent possible, the badges, incidents, and relics of slavery and involuntary servitude.

(11) Both at the time when the 13th, 14th, and 15th amendments to the Constitution of the United States were adopted, and continuing to date, members of certain religious and national origin groups were and are perceived to be distinct ''races''. Thus, in order to eliminate, to the extent possible, the badges, incidents, and relics of slavery, it is necessary to prohibit assaults on the basis of real or perceived religions or national origins, at least to the extent such religions or national origins were regarded as races at the time of the adoption of the 13th, 14th, and 15th amendments to the Constitution of the United States.

(12) Federal jurisdiction over certain violent crimes motivated by bias enables Federal, State, and local authorities to work together as partners in the investigation and prosecution of such crimes.

(13) The problem of crimes motivated by bias is sufficiently serious, widespread, and interstate in nature as to warrant Federal assistance to States and local jurisdictions.

SEC. 3. DEFINITION OF HATE CRIME.

In this Act, the term ''hate crime'' has the same meaning as in section 280003(a) of the Violent Crime Control and Law Enforcement Act of 1994 (28 U.S.C. 994 note).

SEC. 4. SUPPORT FOR CRIMINAL INVESTIGATIONS AND PROSECUTIONS BY STATE AND LOCAL LAW ENFORCEMENT OFFICIALS.

(a) ASSISTANCE OTHER THAN FINANCIAL ASSISTANCE.—

(1) IN GENERAL.—At the request of a law enforcement official of a State or Indian tribe; the Attorney General may provide technical, forensic, prosecutorial, or any other form of assistance in the criminal investigation or prosecution of any crime that—

(A) constitutes a crime of violence (as defined in section 16 of title 18, United States Code);

(B) constitutes a felony under the laws of the State or Indian tribe; and

(C) is motivated by prejudice based on the race, color, religion, national origin, gender, sexual orientation, or disability of the victim, or is a violation of the hate crime laws of the State or Indian tribe.

(2) PRIORITY.—In providing assistance under paragraph (1), the Attorney General shall give priority to crimes committed by offenders who have committed crimes in more than 1 State and to rural jurisdictions that have difficulty covering the extraordinary expenses relating to the investigation or prosecution of the crime.

(b) GRANTS.—

IN GENERAL.—The Attorney General may award grants to assist State, local, and Indian law enforcement officials with the extraordinary expenses associated with the investigation and prosecution of hate crimes.

(2) OFFICE OF JUSTICE PROGRAMS.—In implementing the grant program, the Office of Justice Programs shall work closely with the funded jurisdictions to ensure that the concerns and needs of all affected parties, including community groups and schools, colleges, and universities, are addressed through the local infrastructure developed under the grants.

(3) APPLICATION.—

(A) IN GENERAL.—Each State that desires a grant under this subsection shall submit an application to the Attorney General at such time, in such manner, and accompanied by or containing such information as the Attorney General shall reasonably require.

(B) DATE FOR SUBMISSION.—Applications submitted pursuant to subparagraph (A) shall be submitted during the 60-day period beginning on a date that the Attorney General shall prescribe.

(C) REQUIREMENTS.—A State or political subdivision of a State or tribal official applying for assistance under this subsection shall—

(i) describe the extraordinary purposes for which the grant is needed;

(ii) certify that the State; political subdivision, or Indian tribe lacks the resources necessary to investigate or prosecute the hate crime;

(iii) demonstrate that, in developing a plan to implement the grant, the State, political subdivision, or tribal official has consulted and coordinated with nonprofit, nongovernmental victim services programs that have experience in providing services to victims of hate crimes; and

(iv) certify that any Federal funds received under this subsection will be used to supplement, not supplant, non-Federal funds that would otherwise be available for activities funded under this subsection.

(4) DEADLINE.—An application for a grant under this subsection shall be approved or disapproved by the Attorney General not later than 30 business days after the date on which the Attorney General receives the application.

(5) GRANT AMOUNT.—A grant under this subsection shall not exceed $100,000 for any single jurisdiction within a 1 year period.

(6) REPORT.—Not later than December 31, 2006, the Attorney General shall submit to Congress a report describing the applications submitted for grants under this subsection, the award of such grants, and the purposes for which the grant amounts were expended.

(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $5,000,000 for each of fiscal years 2006 and 2007.

SEC. 5. GRANT PROGRAM.

(a) AUTHORITY TO MAKE GRANTS.—The Office of Justice Programs of the Department of Justice shall award grants, in accordance with such regulations as the Attorney General may prescribe, to State and local programs designed to combat hate crimes committed by juveniles, including programs to train local law enforcement officers in identifying, investigating, prosecuting, and preventing hate crimes.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 6. AUTHORIZATION FOR ADDITIONAL PERSONNEL TO ASSIST STATE AND LOCAL LAW ENFORCEMENT.

There are authorized to be appropriated to the Department of the Treasury and the Department of Justice, including the Community Relations Service, for fiscal years 2006, 2007, and 2008 such sums as are necessary to increase the number of personnel to prevent and respond to alleged violations of section 249 of title 18, United States Code, as added by section 7.

SEC. 7. PROHIBITION OF CERTAIN HATE CRIME ACTS.

(a) IN GENERAL.—Chapter 13 of title 18, United States Code, is amended by adding at the end the following:

§ 249. Hate crime acts

''(a) IN GENERAL.—

''(1) OFFENSES INVOLVING ACTUAL OR PERCEIVED RACE, COLOR, RELIGION, OR NATIONAL ORIGIN.—Whoever, whether or not acting under color of law, willfully causes bodily injury to any person or, through the use of fire, a firearm, or an explosive or incendiary device, attempts to cause bodily injury to any person, because of the actual or perceived race, color, religion, or national origin of any person—

''(A) shall be imprisoned not more than 10 years, fined in accordance with this title, or both; and

''(B) shall be imprisoned for any term of years or for life, fined in accordance with this title, or both, if—

''(i) death results from the offense; or

''(ii) the offense includes kidnaping or an attempt to kidnap, aggravated sexual abuse or an attempt to commit aggravated sexual abuse, or an attempt to kill.

''(2) OFFENSES INVOLVING ACTUAL OR PERCEIVED RELIGION, NATIONAL ORIGIN, GENDER, SEXUAL ORIENTATION, OR DISABILITY.—

''(A) IN GENERAL.—Whoever, whether or not acting under color of law, in any circumstance described in subparagraph (B), willfully causes bodily injury to any person or, through the use of fire, a firearm, or an explosive or incendiary device, attempts to cause bodily injury to any person, because of the actual or perceived religion, national origin, gender, sexual orientation, or disability of any person—

''(i) shall be imprisoned not more than 10 years, fined in accordance with this title, or both; and

''(ii) shall be imprisoned for any term of years or for life, fined in accordance with this title, or both, if—

''(I) death results from the offense; or

''(II) the offense includes kidnaping or an attempt to kidnap, aggravated sexual abuse or an attempt to commit aggravated sexual abuse, or an attempt to kill.

''(B) CIRCUMSTANCES DESCRIBED.—For purposes of subparagraph (A), the circumstances described in this subparagraph are that—

''(i) the conduct described in subparagraph (A) occurs during the course of, or as the result of, the travel of the defendant or the victim—

''(I) across a State line or national border; or

''(II) using a channel, facility, or instrumentality of interstate or foreign commerce;

''(ii) the defendant uses a channel, facility, or instrumentality of interstate or foreign commerce in connection with the conduct described in subparagraph (A);

''(iii) in connection with the conduct described in subparagraph (A), the defendant employs a firearm, explosive or incendiary device, or other weapon that has traveled in interstate or foreign commerce; or

''(iv) the conduct described in subparagraph (A)—

''(I) interferes with commercial or other economic activity in which the victim is engaged at the time of the conduct; or

''(II) otherwise affects interstate or foreign commerce.

''(b) CERTIFICATION REQUIREMENT.—No prosecution of any offense described in this subsection may be undertaken by the United States, except under the certification in writing of the Attorney General, the Deputy Attorney General, the Associate Attorney General, or any Assistant Attorney General specially designated by the Attorney General that—

''(1) he or she has reasonable cause to believe that the actual or perceived race, color, religion, national origin, gender, sexual orientation, or disability of any person was a motivating factor underlying the alleged conduct of the defendant; and

''(2) he or his designee or she or her designee has consulted with State or local law enforcement officials regarding the prosecution and determined that—

''(A) the State does not have jurisdiction or does not intend to exercise jurisdiction;

''(B) the State has requested that the Federal Government assume jurisdiction;

''(C) the State does not object to the Federal Government assuming jurisdiction; or

''(D) the verdict or sentence obtained pursuant to State charges left demonstratively unvindicated the Federal interest in eradicating bias-motivated violence.

''(c) DEFINITIONS.—In this section—

''(1) the term 'explosive or incendiary device' has the meaning given the term in section 232 of this title; and

''(2) the term 'firearm' has the meaning given the term in section 921(a) of this title.''.

(b) TECHNICAL AND CONFORMING AMENDMENT.—The analysis for chapter 13 of title 18, United States Code, is amended by adding at the end the following:

''249. Hate crime acts''.

SEC. 8. DUTIES OF FEDERAL SENTENCING COMMISSION.

(a) AMENDMENT OF FEDERAL SENTENCING GUIDELINES.—Pursuant to the authority provided under section 994 of title 28, United States Code, the United States Sentencing Commission shall study the issue of adult recruitment of juveniles to commit hate crimes and shall, if appropriate, amend the Federal sentencing guidelines to provide sentencing enhancements (in addition to the sentencing enhancement provided for the use of a minor during the commission of an offense) for adult defendants who recruit juveniles to assist in the commission of hate crimes.

(b) CONSISTENCY WITH OTHER GUIDELINES.—In carrying out this section, the United States Sentencing Commission shall—

(1) ensure that there is reasonable consistency with other Federal sentencing guidelines; and

(2) avoid duplicative punishments for substantially the same offense.

SEC. 9. STATISTICS.

Subsection (b)(1) of the first section of the Hate Crimes Statistics Act (28 U.S.C. 534 note) is amended by inserting ''gender,'' after ''race,''.

SEC. 10. SEVERABILITY.

If any provision of this Act, an amendment made by this Act, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this Act, the amendments made by this Act, and the application of the provisions of such to any person or circumstance shall not be affected thereby.

SA 3862. Mr. KERRY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Kids Come First Act of 2006''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) NEED FOR UNIVERSAL COVERAGE.—

(A) Currently, there are 9,000,000 children under the age of 19 that are uninsured. One out of every 8 children are uninsured while 1 in 5 Hispanic children and 1 in 7 African American children are uninsured. Three-quarters, approximately 6,800,000, of these children are eligible but not enrolled in the medicaid program or the State children's health insurance program (SCHIP). Long-range studies found that 1 in 3 children went without health insurance for all or part of 2002 and 2003.

(B) Low-income children are 3 times as likely as children in higher income families to be uninsured. It is estimated that 65 percent of uninsured children have at least 1 parent working full time over the course of the year.

(C) It is estimated that 50 percent of all legal immigrant children in families with income that is less than 200 percent of the Federal poverty line are uninsured. In States without programs to cover immigrant children, 57 percent of non-citizen children are uninsured.

(D) Children in the Southern and Western parts of the United States were nearly 1.7 times more likely to be uninsured than children in the Northeast. In the Northeast, 9.4 percent of children are uninsured while in the Midwest, 8.3 percent are uninsured. The South's rate of uninsured children is 14.3 percent while the West has an uninsured rate of 13 percent.

(E) Children's health care needs are neglected in the United States. One-quarter of young children in the United States are not fully up to date on their basic immunizations. One-third of children with chronic asthma do not get a prescription for the necessary medications to manage the disease.

(F) According to the Centers for Disease Control and Prevention, nearly ½ of all uninsured children have not had a well-child visit in the past year. One out of every 5 children has problems accessing needed care, and 1 out of every 4 children do not receive annual dental exams. One in 6 uninsured children had a delayed or unmet medical need in the past year. Minority children are less likely to receive proven treatments such as prescription medications to treat chronic disease.

(G) There are 7,600,000 young adults between the ages of 19 and 20. In the United States, approximately 28 percent, or 2,100,000 individuals, of this group are uninsured.

(H) Chronic illness and disability among children are on the rise. Children most at risk for chronic illness and disability are children who are most likely to be poor and uninsured.

(2) ROLE OF THE MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.—

(A) The medicaid program and SCHIP serve as a crucial health safety net for 30,000,000 children. During the recent economic downturn and the highest number of uninsured individuals ever recorded in the United States, the medicaid program and SCHIP offset losses in employer-sponsored coverage. While the number of children living in low-income families increased by 2,000,000 between 2000 and 2003, the number of uninsured children fell due to the medicaid program and SCHIP.

(B) In 2003, 25,000,000 children were enrolled in the medicaid program, accounting for ½ of all enrollees and only 19 percent of total program costs.

(C) The medicaid program and SCHIP do more than just fill in the gaps. Gains in public coverage have reduced the percentage of low-income uninsured by a ⅓ from 1997 to 2003. In addition, a recent study found that publicly-insured children are more likely to obtain medical care, preventive care and dental care than similar low-income privately-insured children.

(D) Publicly funded programs such as the medicaid program and SCHIP actually improve children's health. Children who are currently insured by public programs are in better health than they were a year ago. Expansion of coverage for children and pregnant women under the medicaid program and SCHIP reduces rates of avoidable hospitalizations by 22 percent.

(E) Studies have found that children enrolled in public insurance programs experienced a 68 percent improvement in measures of school performance.

(F) Despite the success of expansions in general under the medicaid program and SCHIP, due to current budget constraints, many States have stopped doing aggressive outreach and have raised premiums and cost-sharing requirements on families under these programs. In addition, 8 States stopped enrollment in SCHIP for a period of time between April 2003 and July 2004. As a result, SCHIP enrollment fell by 200,000 children for the first time in the program's history.

(G) It is estimated that nearly 50 percent of children covered through SCHIP do not remain in the program due to reenrollment barriers. A recent study found that between 10 and 40 percent of these children are ''lost'' in the system. Difficult renewal policies and reenrollment barriers make seamless coverage in SCHIP unattainable. Studies indicate that as many as 67 percent of children who were eligible but not enrolled for SCHIP had applied for coverage but were denied due to procedural issues.

(H) While the medicaid program and SCHIP expansions to date have done much to offset what otherwise would have been a significant loss of coverage among children because of declining access to employer coverage, the shortcomings of previous expansions, such as the failure to enroll all eligible children and caps on enrollment in SCHIP because of under-funding, also are clear.

TITLE I—EXPANDED COVERAGE OF CHILDREN UNDER MEDICAID AND SCHIP

SEC. 101. STATE OPTION TO RECEIVE 100 PERCENT FMAP FOR MEDICAL ASSISTANCE FOR CHILDREN IN POVERTY IN EXCHANGE FOR EXPANDED COVERAGE OF CHILDREN IN WORKING POOR FAMILIES UNDER MEDICAID OR SCHIP.

(a) STATE OPTION.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by redesignating section 1939 as section 1940, and by inserting after section 1938 the following:

''STATE OPTION FOR INCREASED FMAP FOR MEDICAL ASSISTANCE FOR CHILDREN IN POVERTY IN EXCHANGE FOR EXPANDED COVERAGE OF CHILDREN IN WORKING POOR FAMILIES UNDER THIS TITLE OR TITLE XXI

''SEC. 1939. (a) 100 PERCENT FMAP.—

''(1) IN GENERAL.—Notwithstanding any other provision of this title, in the case of a State that, through an amendment to each of its State plans under this title and title XXI (or to a waiver of either such plan), agrees to satisfy the conditions described in subsections (b), (c), and (d) the Federal medical assistance percentage shall be 100 percent with respect to the total amount expended by the State for providing medical assistance under this title for each fiscal year quarter beginning on or after the date described in subsection (e) for children whose family income does not exceed 100 percent of the poverty line.

''(2) LIMITATION ON SCOPE OF APPLICATION OF INCREASE.—The increase in the Federal medical assistance percentage for a State under this section shall apply only with respect to the total amount expended for providing medical assistance under this title for a fiscal year quarter for children described in paragraph (1) and shall not apply with respect to—

''(A) any other payments made under this title, including disproportionate share hospital payments described in section 1923;

''(B) payments under title IV or XXI; or

''(C) any payments made under this title or title XXI that are based on the enhanced FMAP described in section 2105(b).

''(b) ELIGIBILITY EXPANSIONS.—The condition described in this subsection is that the State agrees to do the following:

''(1) COVERAGE UNDER MEDICAID OR SCHIP FOR CHILDREN IN FAMILIES WHOSE INCOME DOES NOT EXCEED 300 PERCENT OF THE POVERTY LINE.—

''(A) IN GENERAL.—The State agrees to provide medical assistance under this title or child health assistance under title XXI to children whose family income exceeds the medicaid applicable income level (as defined in section 2110(b)(4) but by substituting 'January 1, 2006' for 'March 31, 1997'), but does not exceed 300 percent of the poverty line.

''(B) STATE OPTION TO EXPAND COVERAGE THROUGH SUBSIDIZED PURCHASE OF FAMILY COVERAGE.—A State may elect to carry out subparagraph (A) through the provision of assistance for the purchase of dependent coverage under a group health plan or health insurance coverage if—

''(i) the dependent coverage is consistent with the benefit standards under this title or title XXI, as approved by the Secretary; and

''(ii) the State provides additional benefits under this title or title XXI.

''(C) DEEMED SATISFACTION FOR CERTAIN STATES.—A State that, as of January 1, 2006, provides medical assistance under this title or child health assistance under title XXI to children whose family income is 300 percent of the poverty line shall be deemed to satisfy this paragraph.

''(2) COVERAGE FOR CHILDREN UNDER AGE 21.—The State agrees to define a child for

purposes of this title and title XXI as an individual who has not attained 21 years of age.

''(3) OPPORTUNITY FOR HIGHER INCOME CHILDREN TO PURCHASE SCHIP COVERAGE.—The State agrees to permit any child whose family income exceeds 300 percent of the poverty line to purchase full or additional coverage under title XXI at the full cost of providing such coverage, as determined by the State.

''(4) COVERAGE FOR LEGAL IMMIGRANT CHILDREN.—The State agrees to—

''(A) provide medical assistance under this title and child health assistance under title XXI for alien children who are lawfully residing in the United States (including battered aliens described in section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and who are otherwise eligible for such assistance in accordance with section 1903(v)(4) and 2107(e)(1)(E); and

''(B) not establish or enforce barriers that deter applications by such aliens, including through the application of the removal of the barriers described in subsection (c).

''(c) REMOVAL OF ENROLLMENT AND ACCESS BARRIERS.—The condition described in this subsection is that the State agrees to do the following:

''(1) PRESUMPTIVE ELIGIBILITY FOR CHILDREN.—The State agrees to—

''(A) provide presumptive eligibility for children under this title and title XXI in accordance with section 1920A;

''(B) treat any items or services that are provided to an uncovered child (as defined in section 2110(c)(8)) who is determined ineligible for medical assistance under this title as child health assistance for purposes of paying a provider of such items or services, so long as such items or services would be considered child health assistance for a targeted low-income child under title XXI.

''(2) ADOPTION OF 12-MONTH CONTINUOUS ENROLLMENT.—The State agrees to provide that eligibility for assistance under this title and title XXI shall not be regularly redetermined more often than once every year for children.

''(3) ACCEPTANCE OF SELF-DECLARATION OF INCOME.—The State agrees to permit the family of a child applying for medical assistance under this title or child health assistance under title XXI to declare and certify by signature under penalty of perjury family income for purposes of collecting financial eligibility information.

''(4) ADOPTION OF ACCEPTANCE OF ELIGIBILITY DETERMINATIONS FOR OTHER ASSISTANCE PROGRAMS.—The State agrees to accept determinations (made within a reasonable period, as found by the State, before its use for this purpose) of an individual's family or household income made by a Federal or State agency (or a public or private entity making such determination on behalf of such agency), including the agencies administering the Food Stamp Act of 1977, the Richard B. Russell National School Lunch Act, and the Child Nutrition Act of 1966, notwithstanding any differences in budget unit, disregard, deeming, or other methodology, but only if—

''(A) such agency has fiscal liabilities or responsibilities affected or potentially affected by such determinations; and

''(B) any information furnished by such agency pursuant to this subparagraph is used solely for purposes of determining eligibility for medical assistance under this title or for child health assistance under title XXI.

''(5) NO ASSETS TEST.—The State agrees to not (or demonstrates that it does not) apply any assets or resources test for eligibility under this title or title XXI with respect to children.

''(6) ELIGIBILITY DETERMINATIONS AND REDETERMINATIONS.—

''(A) IN GENERAL.—The State agrees for purposes of initial eligibility determinations and redeterminations of children under this title and title XXI not to require a face-to-face interview and to permit applications and renewals by mail, telephone, and the Internet.

''(B) NONDUPLICATION OF INFORMATION.—

''(i) IN GENERAL.—For purposes of redeterminations of eligibility for currently or previously enrolled children under this title and title XXI, the State agrees to use all information in its possession (including information available to the State under other Federal or State programs) to determine eligibility or redetermine continued eligibility before seeking similar information from parents.

''(ii) RULE OF CONSTRUCTION.—Nothing in clause (i) shall be construed as limiting any obligation of a State to provide notice and a fair hearing before denying, terminating, or reducing a child's coverage based on such information in the possession of the State.

''(7) NO WAITING LIST FOR CHILDREN UNDER SCHIP.—The State agrees to not impose any numerical limitation, waiting list, waiting period, or similar limitation on the eligibility of children for child health assistance under title XXI or to establish or enforce other barriers to the enrollment of eligible children based on the date of their application for coverage.

''(8) ADEQUATE PROVIDER PAYMENT RATES.—The State agrees to—

''(A) establish payment rates for children's health care providers under this title that are no less than the average of payment rates for similar services for such providers provided under the benchmark benefit packages described in section 2103(b);

''(B) establish such rates in amounts that are sufficient to ensure that children enrolled under this title or title XXI have adequate access to comprehensive care, in accordance with the requirements of section 1902(a)(30)(A); and

''(C) include provisions in its contracts with providers under this title guaranteeing compliance with these requirements.

''(d) MAINTENANCE OF MEDICAID ELIGIBILITY LEVELS FOR CHILDREN.—

''(1) IN GENERAL.—The condition described in this subsection is that the State agrees to maintain eligibility income, resources, and methodologies applied under this title (including under a waiver of such title or under section 1115) with respect to children that are no more restrictive than the eligibility income, resources, and methodologies applied with respect to children under this title (including under such a waiver) as of January 1, 2006.

''(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as implying that a State does not have to comply with the minimum income levels required for children under section 1902(l)(2).

''(e) DATE DESCRIBED.—The date described in this subsection is the date on which, with respect to a State, a plan amendment that satisfies the requirements of subsections (b), (c), and (d) is approved by the Secretary.

''(f) DEFINITION OF POVERTY LINE.—In this section, the term 'poverty line' has the meaning given that term in section 2110(c)(5).''.

(b) CONFORMING AMENDMENTS.—

(1) The third sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by inserting before the period the following: '', and with respect to amounts expended for medical assistance for children on or after the date described in subsection (d) of section 1939, in the case of a State that has, in accordance with such section, an approved plan amendment under this title and title XXI''.

(2) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended—

(A) in subparagraph (C), by adding ''or'' after ''section 1611(b)(1),''; and

(B) by inserting after subparagraph (C), the following:

''(D) who would not receive such medical assistance but for State electing the option under section 1939 and satisfying the conditions described in subsections (b), (c), and (d) of such section,''.

SEC. 102. ELIMINATION OF CAP ON SCHIP FUNDING FOR STATES THAT EXPAND ELIGIBILITY FOR CHILDREN.

(a) IN GENERAL.—Section 2105 of the Social Security Act (42 U.S.C. 1397dd) is amended by adding at the end the following:

''(h) GUARANTEED FUNDING FOR CHILD HEALTH ASSISTANCE FOR COVERAGE EXPANSION STATES.—

''(1) IN GENERAL.—Only in the case of a State that has, in accordance with section 1939, an approved plan amendment under this title and title XIX, any payment cap that would otherwise apply to the State under this title as a result of having expended all allotments available for expenditure by the State with respect to a fiscal year shall not apply with respect to amounts expended by the State on or after the date described in section 1939(d).

''(2) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary for the purpose of paying a State described in paragraph (1) for each quarter beginning on or after the date described in section 1939(d), an amount equal to the enhanced FMAP of expenditures described in paragraph (1) and incurred during such quarter.''.

(b) CONFORMING AMENDMENTS.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended—

(1) in subsection (a), by inserting ''subject to section 2105(h),'' after ''under this section,'';

(2) in subsection (b)(1), by inserting ''and section 2105(h)'' after ''Subject to paragraph (4)''; and

(3) in subsection (c)(1), by inserting ''subject to section 2105(h),'' after ''for a fiscal year,''.

TITLE II—STATE OPTIONS FOR INCREMENTAL CHILD COVERAGE EXPANSIONS

SEC. 201. STATE OPTION TO PROVIDE ADDITIONAL SCHIP COVERAGE TO CHILDREN WHO HAVE OTHER HEALTH COVERAGE.

(a) IN GENERAL.—Section 2110(b) of the Social Security Act (42 U.S.C. 1397jj(b)) is amended—

(1) in paragraph (1)(C), by inserting '', subject to paragraph (5),'' after ''under title XIX or''; and

(2) by adding at the end the following new paragraph:

''(5) STATE OPTION TO PROVIDE ADDITIONAL COVERAGE.—

''(A) IN GENERAL.—A State may waive the requirement of paragraph (1)(C) that a targeted low-income child may not be covered under a group health plan or under health insurance coverage in order to provide—

''(i) items or services that are not covered, or are only partially covered, under such plan or coverage; or

''(ii) cost-sharing protection.

''(B) ELIGIBILITY.—In waiving such requirement, a State may limit the application of the waiver to children whose family income does not exceed a level specified by the State, so long as the level so specified does not exceed the maximum income level otherwise established for other children under the State child health plan.

''(C) CONTINUED APPLICATION OF DUTY TO PREVENT SUBSTITUTION OF EXISTING COVERAGE.—Nothing in this paragraph shall be construed as modifying the application of section 2102(b)(3)(C) to a State.''.

(b) APPLICATION OF ENHANCED MATCH UNDER MEDICAID.—Section 1905 of such Act (42 U.S.C. 1396d) is amended—

(1) in subsection (b), in the fourth sentence, by striking ''subsection (u)(3)'' and inserting ''(u)(3), or (u)(4)''; and

(2) in subsection (u), by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (3) the following:

''(4) For purposes of subsection (b), the expenditures described in this paragraph are expenditures for items and services for children described in section 2110(b)(5).''.

(c) APPLICATION OF SECONDARY PAYOR PROVISIONS.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)) is amended—

(1) by redesignating subparagraphs (B) through (D) as subparagraphs (C) through (E), respectively; and

(2) by inserting after subparagraph (A) the following new subparagraph:

''(B) Section 1902(a)(25) (relating to coordination of benefits and secondary payor provisions) with respect to children covered under a waiver described in section 2110(b)(5).''.

SEC. 202. STATE OPTION TO ENROLL LOW-INCOME CHILDREN OF STATE EMPLOYEES IN SCHIP.

Section 2110(b)(2) of the Social Security Act (42 U.S.C. 1397jj(b)(2)) is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively and realigning the left margins of such clauses appropriately;

(2) by striking ''Such term'' and inserting the following:

''(A) IN GENERAL.—Such term''; and

(3) by adding at the end the following:

''(B) STATE OPTION TO ENROLL LOW-INCOME CHILDREN OF STATE EMPLOYEES.—At the option of a State, subparagraph (A)(ii) shall not apply to any low-income child who would otherwise be eligible for child health assistance under this title but for such subparagraph.''.

SEC. 203. OPTIONAL COVERAGE OF LEGAL IMMIGRANT CHILDREN UNDER MEDICAID AND SCHIP.

(a) MEDICAID PROGRAM.—Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

(2) by adding at the end the following:

''(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and who are otherwise eligible for such assistance, within any of the following eligibility categories:

''(i) CHILDREN.—Children (as defined under such plan), including optional targeted low-income children described in section 1905(u)(2)(B).

''(B)(i) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

''(ii) The provisions of sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 shall not apply to a State that makes an election under subparagraph (A).''.

(b) TITLE XXI.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following:

''(E) Section 1903(v)(4) (relating to optional coverage of permanent resident alien children), but only if the State has elected to apply such section to that category of children under title XIX.''.

SEC. 204. STATE OPTION FOR PASSIVE RENEWAL OF ELIGIBILITY FOR CHILDREN UNDER MEDICAID AND SCHIP.

(a) IN GENERAL.—Section 1902(l) of the Social Security Act (42 U.S.C. 1396a(l)) is amended by adding at the end the following:

''(5) Notwithstanding any other provision of this title, a State may provide that an individual who has not attained 21 years of age who has been determined eligible for medical assistance under this title shall remain eligible for medical assistance until such time as the State has information demonstrating that the individual is no longer so eligible.''.

(b) APPLICATION UNDER TITLE XXI.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)) is amended—

(1) by redesignating subparagraphs (B) through (D) as subparagraphs (C) through (E), respectively; and

(2) by inserting after subparagraph (A), the following:

''(B) Section 1902(l)(5) (relating to passive renewal of eligibility for children).''.

TITLE III—TAX INCENTIVES FOR HEALTH INSURANCE COVERAGE OF CHILDREN

SEC. 301. REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE OF CHILDREN.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 36 as section 37 and by inserting after section 35 the following new section:

''SEC. 36. HEALTH INSURANCE COVERAGE OF CHILDREN.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to so much of the amount paid during the taxable year, not compensated for by insurance or otherwise, for qualified health insurance for each dependent child of the taxpayer, as exceeds 5 percent of the adjusted gross income of such taxpayer for such taxable year.

''(b) DEPENDENT CHILD.—For purposes of this section, the term 'dependent child' means any child (as defined in section 152(f)(1)) who has not attained the age of 19 as of the close of the calendar year in which the taxable year of the taxpayer begins and with respect to whom a deduction under section 151 is allowable to the taxpayer.

''(c) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified health insurance' means insurance, either employer-provided or made available under title XIX or XXI of the Social Security Act, which constitutes medical care as defined in section 213(d) without regard to—

''(A) paragraph (1)(C) thereof, and

''(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance contracts.

''(2) EXCLUSION OF CERTAIN OTHER CONTRACTS.—Such term shall not include insurance if a substantial portion of its benefits are excepted benefits (as defined in section 9832(c)).

''(d) MEDICAL SAVINGS ACCOUNT AND HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—

''(1) IN GENERAL.—If a deduction would (but for paragraph (2)) be allowed under section 220 or 223 to the taxpayer for a payment for the taxable year to the medical savings account or health savings account of an individual, subsection (a) shall be applied by treating such payment as a payment for qualified health insurance for such individual.

''(2) DENIAL OF DOUBLE BENEFIT.—No deduction shall be allowed under section 220 or 223 for that portion of the payments otherwise allowable as a deduction under section 220 or 223 for the taxable year which is equal to the amount of credit allowed for such taxable year by reason of this subsection.

''(e) SPECIAL RULES.—

''(1) DETERMINATION OF INSURANCE COSTS.—The Secretary shall provide rules for the allocation of the cost of any qualified health insurance for family coverage to the coverage of any dependent child under such insurance.

''(2) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—In the case of a taxpayer who is eligible to deduct any amount under section 162(l) for the taxable year, this section shall apply only if the taxpayer elects not to claim any amount as a deduction under such section for such year.

''(3) COORDINATION WITH MEDICAL EXPENSE AND HIGH DEDUCTIBLE HEALTH PLAN DEDUCTIONS.—The amount which would (but for this paragraph) be taken into account by the taxpayer under section 213 or 224 for the taxable year shall be reduced by the credit (if any) allowed by this section to the taxpayer for such year.

''(4) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(5) DENIAL OF DOUBLE BENEFIT.—No credit shall be allowed under subsection (a) if the credit under section 35 is allowed and no credit shall be allowed under 35 if a credit is allowed under this section.

''(6) ELECTION NOT TO CLAIM CREDIT.—This section shall not apply to a taxpayer for any taxable year if such taxpayer elects to have this section not apply for such taxable year.''.

(b) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to information concerning transactions with other persons) is amended by inserting after section 6050T the following new section:

''SEC. 6050U. RETURNS RELATING TO PAYMENTS FOR QUALIFIED HEALTH INSURANCE.

''(a) IN GENERAL.—Any governmental unit or any person who, in connection with a trade or business conducted by such person, receives payments during any calendar year from any individual for coverage of a dependent child (as defined in section 36(b)) of such individual under creditable health insurance, shall make the return described in subsection (b) (at such time as the Secretary may by regulations prescribe) with respect to each individual from whom such payments were received.

''(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

''(A) the name, address, and TIN of the individual from whom payments described in subsection (a) were received,

''(B) the name, address, and TIN of each dependent child (as so defined) who was provided by such person with coverage under creditable health insurance by reason of such payments and the period of such coverage, and

''(C) such other information as the Secretary may reasonably prescribe.

''(c) CREDITABLE HEALTH INSURANCE.—For purposes of this section, the term 'creditable health insurance' means qualified health insurance (as defined in section 36(c)).

''(d) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required under subsection (b)(2)(A) to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person,

''(2) the aggregate amount of payments described in subsection (a) received by the person required to make such return from the individual to whom the statement is required to be furnished, and

''(3) the information required under subsection (b)(2)(B) with respect to such payments.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(e) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xiii) through (xviii) as clauses (xiv) through (xix), respectively, and by inserting after clause (xii) the following new clause:

''(xiii) section 6050U (relating to returns relating to payments for qualified health insurance),''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of the next to last subparagraph, by striking the period at the end of the last subparagraph and inserting '', or'', and by adding at the end the following new subparagraph:

''(CC) section 6050U(d) (relating to returns relating to payments for qualified health insurance).''.

(3) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050T the following new item:

''Sec. 6050U. Returns relating to payments for qualified health insurance.''.

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period '', or from section 36 of such Code''.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the last item and inserting the following new items:

''Sec. 36. Health insurance coverage of children.

''Sec. 37. Overpayments of tax.''. Q

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2006.

SEC. 302. FORFEITURE OF PERSONAL EXEMPTION FOR ANY CHILD NOT COVERED BY HEALTH INSURANCE.

(a) IN GENERAL.—Section 151(d) of the Internal Revenue Code of 1986 (relating to exemption amount) is amended by adding at the end the following new paragraph:

''(5) REDUCTION OF EXEMPTION AMOUNT FOR ANY CHILD NOT COVERED BY HEALTH INSURANCE.—

''(A) IN GENERAL.—Except as otherwise provided in this paragraph, the exemption amount otherwise determined under this subsection for any dependent child (as defined in section 36(b)) for any taxable year shall be reduced by the same percentage as the percentage of such taxable year during which such dependent child was not covered by qualified health insurance (as defined in section 36(c)).

''(B) FULL REDUCTION IF NO PROOF OF COVERAGE IS PROVIDED.—For purposes of subparagraph (A), in the case of any taxpayer who fails to attach to the return of tax for any taxable year a copy of the statement furnished to such taxpayer under section 6050U, the percentage reduction under such subparagraph shall be deemed to be 100 percent.

''(C) NONAPPLICATION OF PARAGRAPH TO TAXPAYERS IN LOWEST TAX BRACKET.—This paragraph shall not apply to any taxpayer whose taxable income for the taxable year does not exceed the initial bracket amount determined under section 1(i)(1)(B).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2006.

TITLE IV—MISCELLANEOUS

SEC. 401. REQUIREMENT FOR GROUP MARKET HEALTH INSURERS TO OFFER DEPENDENT COVERAGE OPTION FOR WORKERS WITH CHILDREN.

(a) ERISA.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

''SEC. 714. REQUIREMENT TO OFFER OPTION TO PURCHASE DEPENDENT COVERAGE FOR CHILDREN.

''(a) REQUIREMENTS FOR COVERAGE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, shall offer an individual who is enrolled in such coverage the option to purchase dependent coverage for a child of the individual.

''(b) NO EMPLOYER CONTRIBUTION REQUIRED.—An employer shall not be required to contribute to the cost of purchasing dependent coverage for a child by an individual who is an employee of such employer.

''(c) DEFINITION OF CHILD.—In this section, the term 'child' means an individual who has not attained 21 years of age.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001) is amended by inserting after the item relating to section 713 the following:

''Sec. 714. Requirement to offer option to purchase dependent coverage for children.''.

(b) PUBLIC HEALTH SERVICE ACT.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following:

''SEC. 2707. REQUIREMENT TO OFFER OPTION TO PURCHASE DEPENDENT COVERAGE FOR CHILDREN.

''(a) REQUIREMENTS FOR COVERAGE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, shall offer an individual who is enrolled in such coverage the option to purchase dependent coverage for a child of the individual.

''(b) NO EMPLOYER CONTRIBUTION REQUIRED.—An employer shall not be required to contribute to the cost of purchasing dependent coverage for a child by an individual who is an employee of such employer.

''(c) DEFINITION OF CHILD.—In this section, the term 'child' means an individual who has not attained 21 years of age.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2007.

SEC. 402. EFFECTIVE DATE.

Unless otherwise provided, the amendments made by this Act shall take effect on October 1, 2006, and shall apply to child health assistance and medical assistance provided on or after that date without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

TITLE V—REVENUE PROVISION

SEC. 501. PARTIAL REPEAL OF RATE REDUCTION IN THE HIGHEST INCOME TAX BRACKET.

Section 1(i)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following flush sentence:

''In the case of taxable years beginning during calendar year 2006 and thereafter, the final item in the fourth column in the preceding table shall be applied by substituting for '35.0%' such rate as the Secretary determines is necessary to provide sufficient revenues to offset the Federal outlays required to implement the provisions of, and amendments made by, the Kids Come First Act of 2006.''.

SA 3863. Mr. SMITH submitted an amendment intended to be proposed by him to the bill S. 1955 to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

In section 2922 of the Public Health Service Act, as added by section 201 of the bill, strike subsection (a) and insert the following:

''(a) BENEFIT CHOICE OPTIONS.—

''(1) DEVELOPMENT.—Not later than 6 months after the date of enactment of this title, the Secretary shall issue, by interim final rule, Benefit Choice Standards that implement a standard benefit package as provided for in this part.

''(2) REQUIREMENT.—The Benefit Choice Standards shall provide that a health insurance issuer in a State, may offer a coverage plan or plan in the small group market, individual market, large group market, or through a small business health plan, that does not comply with one or more mandates regarding covered benefits, services, or category of provider as may be in effect in such State with respect to such market or markets (either prior to or following the date of enactment of this title), if such coverage or plan provides for coverage of a standard benefit package as provided for in paragraph (3).

''(3) STANDARD BENEFIT PACKAGE.—A health insurance issuer described in paragraph (2) shall offer to purchasers (including, with respect to a small business health plan, the participating employers of such plan) a plan that, at a minimum, provides coverage for such benefits, services, and categories of providers as are required under the laws of at least 25 States, as determined by the Secretary.

''(4) PUBLICATION OF BENEFIT PACKAGE.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary shall publish in the Federal Register

the standard benefit package required under this subsection. In making such publication the Secretary shall resolve any variations that exist in the scope of the benefits, services, and categories of providers required under the laws of the States considered by the Secretary for purposes of paragraph (3).

''(5) UPDATING OF BENEFIT PACKAGE.—Not later than 2 years after the date on which the standard benefit package is issued under paragraph (3), and every 2 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall update the package. The Secretary shall issue the updated package by regulation, and such updated package shall be effective upon the first plan year following the issuance of such regulation.

SA 3864. Mr. SMITH submitted an amendment intended to be proposed by him to the bill S. 1955 to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the end of the amendment, add the following:

''(____) PROVISION OF MENTAL HEALTH BENEFITS.—The standard benefit package under this part shall require that health plans include coverage (and cost sharing if applicable) for mental health care in a manner that is comparable to the coverage (and cost sharing if applicable) provided under such plan for items and services relating to physical health.

SA 3865. Mr. SMITH submitted an amendment intended to be proposed by him to the bill S. 1955 to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

In section 2922(a) of the Public Health Service Act, as added by section 201 of the bill, add at the end the following:

''(5) APPLICATION OF COST SHARING.—A health insurance issuer in a State that offers a basic option plan as provided for in paragraph (2) and an enhanced option plan as provided for in paragraph (3), shall ensure that any cost sharing required under either such option is comparable, with respect to dollar amounts, to the cost sharing required under the other such option.

SA 3866. Mr. SMITH submitted an amendment intended to be proposed by him to the bill S. 1955 to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

In section 2922(a) of the Public Health Service Act, as added by section 201 of the bill, add at the end the following:

''(5) PROVISION OF MENTAL HEALTH BENEFITS.—A health insurance issuer in a State that offers a basic option plan as provided for in paragraph (2) and an enhanced option plan as provided for in paragraph (3), shall ensure that each such plan provides coverage (and cost sharing if applicable) for mental health care in a manner that is comparable to the coverage (and cost sharing if applicable) provided under each such plan for items and services relating to physical health.

SA 3867. Ms. SNOWE submitted an amendment intended to be proposed by her to the bill S. 1955 to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. NEGOTIATING FAIR PRICES FOR MEDICARE PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 1860D–11 (42 U.S.C. 1395w–111) is amended by striking subsection (i) (relating to noninterference) and inserting the following:

''(i) AUTHORITY TO NEGOTIATE PRICES WITH MANUFACTURERS.—

''(1) IN GENERAL.—Subject to paragraph (4), in order to ensure that beneficiaries enrolled under prescription drug plans and MA–PD plans pay the lowest possible price, the Secretary shall have authority similar to that of other Federal entities that purchase prescription drugs in bulk to negotiate contracts with manufacturers of covered part D drugs, consistent with the requirements and in furtherance of the goals of providing quality care and containing costs under this part.

''(2) MANDATORY RESPONSIBILITIES.—The Secretary shall be required to—

''(A) negotiate contracts with manufacturers of covered part D drugs for each fallback prescription drug plan under subsection (g); and

''(B) participate in negotiation of contracts of any covered part D drug upon request of an approved prescription drug plan or MA–PD plan.

''(3) RULE OF CONSTRUCTION.—Nothing in paragraph (2) shall be construed to limit the authority of the Secretary under paragraph (1) to the mandatory responsibilities under paragraph (2).

''(4) NO PARTICULAR FORMULARY OR PRICE STRUCTURE.—In order to promote competition under this part and in carrying out this part, the Secretary may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of enactment of this Act.

SA 3868. Mr. OBAMA submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Hospital Quality Report Card Act of 2006''.

SEC. 2. PURPOSE.

The purpose of this Act is to expand hospital quality reporting by establishing the Hospital Quality Report Card Initiative under the Medicare program to ensure that hospital quality measures data are readily available and accessible in order to—

(1) assist patients and consumers in making decisions about where to get health care;

(2) assist purchasers and insurers in making decisions that determine where employees, subscribers, members, or participants are able to go for their health care;

(3) assist health care providers in identifying opportunities for quality improvement and cost containment; and

(4) enhance the understanding of policy makers and public officials of health care issues, raise public awareness of hospital quality issues, and to help constituents of such policy makers and officials identify quality health care options.

SEC. 3. HOSPITAL QUALITY REPORT CARD INITIATIVE.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''SEC. 1898. HOSPITAL QUALITY REPORT CARD INITIATIVE.

''(a) IN GENERAL.—Not later than 18 months after the date of the enactment of the Hospital Quality Report Card Act of 2006, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the 'Administrator') and in consultation with the Director of the Agency for Healthcare Research and Quality, shall, directly or through contracts with States, establish and implement a Hospital Quality Report Card Initiative (in this section referred to as the 'Initiative') to report on health care quality in subsection (d) hospitals.

''(b) SUBSECTION (d) HOSPITAL.—For purposes of this section, the term 'subsection (d) hospital' has the meaning given such term in section 1886(d)(1)(B).

''(c) REQUIREMENTS OF INITIATIVE.—

''(1) QUALITY MEASUREMENT REPORTS FOR HOSPITALS.—

''(A) QUALITY MEASURES.—Not less than 2 times each year, the Secretary shall publish reports on hospital quality. Such reports shall include quality measures data submitted under section 1886(b)(3)(B)(viii), and other data as feasible, that allow for an assessment of health care—

''(i) effectiveness;

''(ii) safety;

''(iii) timeliness;

''(iv) efficiency;

''(v) patient-centeredness; and

''(vi) equity.

''(B) REPORT CARD FEATURES.—In collecting and reporting data as provided for under subparagraph (A), the Secretary shall include hospital information, as possible, relating to—

''(i) staffing levels of nurses and other health professionals, as appropriate;

''(ii) rates of nosocomial infections;

''(iii) the volume of various procedures performed;

''(iv) the availability of interpreter services on-site;

''(v) the accreditation of hospitals, as well as sanctions and other violations found by accreditation or State licensing boards;

''(vi) the quality of care for various patient populations, including pediatric populations and racial and ethnic minority populations;

''(vii) the availability of emergency rooms, intensive care units, obstetrical units, and burn units;

''(viii) the quality of care in various hospital settings, including inpatient, outpatient, emergency, maternity, and intensive care unit settings;

''(ix) the use of health information technology, telemedicine, and electronic medical records;

''(x) ongoing patient safety initiatives; and

''(xi) other measures determined appropriate by the Secretary.

''(C) TAILORING OF HOSPITAL QUALITY REPORTS.—The Director of the Agency for Healthcare Research and Quality may modify and publish hospital reports to include quality measures for diseases and health conditions of particular relevance to certain regions, States, or local areas.

''(D) RISK ADJUSTMENT.—

''(i) IN GENERAL.—In reporting data as provided for under subparagraph (A), the Secretary may risk adjust quality measures to account for differences relating to—

''(I) the characteristics of the reporting hospital, such as licensed bed size, geography, teaching hospital status, and profit status; and

''(II) patient characteristics, such as health status, severity of illness, insurance status, and socioeconomic status.

''(ii) AVAILABILITY OF UNADJUSTED DATA.—If the Secretary reports data under subparagraph (A) using risk-adjusted quality measures, the Secretary shall establish procedures for making the unadjusted data available to the public in a manner determined appropriate by the Secretary.

''(E) COSTS.—The Secretary shall—

''(i) compile data relating to the average hospital cost for ICD-9 conditions for which quality measures data are collected; and

''(ii) report such information in a manner that allows cost comparisons between or among subsection (d) hospitals.

''(F) VERIFICATION.—Under the Initiative, the Secretary may verify data reported under this paragraph to ensure accuracy and validity.

''(G) DISCLOSURE.—The Secretary shall disclose the entire methodology for the reporting of data under this paragraph to all relevant organizations and all subsection (d) hospitals that are the subject of any such information that is to be made available to the public prior to the public disclosure of such information.

''(H) PUBLIC INPUT.—The Secretary shall provide an opportunity for public review and comment with respect to the quality measures to be reported for subsection (d) hospitals under this section for at least 60 days prior to the finalization by the Secretary of the quality measures to be used for such hospitals.

''(I) AVAILABILITY OF REPORTS AND FINDINGS.—

''(i) ELECTRONIC AVAILABILITY.—The Secretary shall ensure that reports are made available under this section in an electronic format, in an understandable manner with respect to various populations (including those with low functional health literacy), and in a manner that allows health care quality comparisons to be made between local hospitals.

''(ii) FINDINGS.—The Secretary shall establish procedures for making report findings available to the public, upon request, in a non-electronic format, such as through the toll-free telephone number 1–800–MEDICARE.

''(J) IDENTIFICATION OF METHODOLOGY.—The analytic methodologies and limitations on data sources utilized by the Secretary to develop and disseminate the comparative data under this section shall be identified and acknowledged as part of the dissemination of such data, and include the appropriate and inappropriate uses of such data.

''(K) ADVERSE SELECTION OF PATIENTS.—On at least an annual basis, the Secretary shall compare quality measures data submitted by each subsection (d) hospital under section 1886(b)(3)(B)(viii) with data submitted in the prior year or years by the same hospital in order to identify and report actions that would lead to false or artificial improvements in the hospital's quality measurements, including—

''(i) adverse selection against patients with severe illness or other factors that predispose patients to poor health outcomes; and

''(ii) provision of health care that does not meet established recommendations or accepted standards for care.

''(2) DATA SAFEGUARDS.—

''(A) UNAUTHORIZED USE AND DISCLOSURE.—The Secretary shall develop and implement effective safeguards to protect against the unauthorized use or disclosure of hospital data that is reported under this section.

''(B) INACCURATE INFORMATION.—The Secretary shall develop and implement effective safeguards to protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective hospital data.

''(C) IDENTIFIABLE DATA.—The Secretary shall ensure that identifiable patient data shall not be released to the public.

''(d) GRANTS AND TECHNICAL ASSISTANCE.—The Secretary may award grants to national or State organizations, partnerships, or other entities that may assist with hospital quality improvement.

''(e) HOSPITAL QUALITY ADVISORY COMMITTEE.—

''(1) ESTABLISHMENT.—The Administrator, in consultation with the Director of the Agency for Healthcare Research and Quality, shall establish the Hospital Quality Advisory Committee (in this subsection referred to as the 'Advisory Committee') to provide advice to the Administrator on the submission, collection, and reporting of quality measures data. The Administrator shall serve as the chairperson of the Advisory Committee.

''(2) MEMBERSHIP.—The Advisory Committee shall include representatives of the following (except with respect to subparagraphs (A) through (D), to be appointed by the Administrator):

''(A) The Agency for Healthcare Research and Quality.

''(B) The Health Resources and Services Administration.

''(C) The Department of Veterans Affairs.

''(D) The Centers for Disease Control and Prevention.

''(E) National membership organizations that focus on health care quality improvement.

''(F) Public and private hospitals.

''(G) Physicians, nurses, and other health professionals.

''(H) Patients and patient advocates.

''(I) Health insurance purchasers and other payers.

''(J) Health researchers, policymakers, and other experts in the field of health care quality.

''(K) Health care accreditation entities.

''(L) Other agencies and groups as determined appropriate by the Administrator.

''(3) DUTIES.—The Advisory Committee shall review and provide guidance and recommendations to the Administrator on—

''(A) the establishment of the Initiative;

''(B) integration and coordination of Federal quality measures data submission requirements, to avoid needless duplication and inefficiency;

''(C) legal and regulatory barriers that may hinder quality measures data collection and reporting; and

''(D) necessary technical and financial assistance to encourage quality measures data collection and reporting;

''(4) STAFF AND RESOURCES.—The Administrator shall provide the Advisory Committee with appropriate staff and resources for the functioning of the Advisory Committee.

''(5) DURATION.—The Advisory Committee shall terminate at the discretion of the Administrator, but in no event later than 5 years after the date of enactment of this section.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2007 through 2016.''.

(b) CONFORMING AMENDMENT.—Section 1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii)), as added by section 5001 of the Deficit Reduction Act of 2005, is amended to read as follows:

''(VII) The Secretary shall use the data submitted under this clause for the Hospital Quality Report Card Initiative under section 1898.''.

SEC. 4. EVALUATION OF THE HOSPITAL QUALITY REPORT CARD INITIATIVE.

(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, directly or through contract, shall evaluate and periodically report to Congress on the effectiveness of the Hospital Quality Report Card Initiative established under section 1898 of the Social Security Act, as added by section 3, including the effectiveness of the Initiative in meeting the purpose described in section 2. The Director shall make such reports available to the public.

(b) RESEARCH.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall use the outcomes from the evaluation conducted pursuant to subsection (a) to increase the usefulness of the Hospital Quality Report Card Initiative, particularly for patients, as necessary.

SA 3869. Mr. OBAMA submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Care for Hybrids Act''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The United States imports over half the oil it consumes.

(2) According to present trends, the United States reliance on foreign oil will increase to 68 percent of its total consumption by 2025.

(3) With only 3 percent of the world's known oil reserves, the health of the United States economy is dependent on world oil prices.

(4) World oil prices are overwhelmingly dictated by countries other than the United States, thus endangering our economic and national security.

(5) Legacy health care costs associated with retiree workers are an increasing burden on the global competitiveness of American industries.

(6) American automakers have lagged behind their foreign competitors in producing

hybrid and other energy efficient automobiles.

(7) Innovative uses of new technology in automobiles in the United States will help retain American jobs, support health care obligations for retiring workers in the automotive sector, decrease America's dependence on foreign oil, and address pressing environmental concerns.

TITLE I—PROGRAM

SEC. 101. COORDINATING TASK FORCE.

Not later than 6 months after the date of enactment of this Act, the Secretary of Energy, the Secretary of Health and Human Services, the Secretary of Transportation, and the Secretary of the Treasury shall establish, and appoint an equal number of representatives to, a task force (referred to in this Act as the ''task force'') to administer the program established under this Act.

SEC. 102. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the task force established under section 101 shall establish a program to provide financial assistance to eligible domestic automobile manufacturers for the costs incurred in providing health benefits to their retired employees.

(b) CONSULTATION.—In establishing the program under subsection (a), the task force shall consult with representatives from the domestic automobile manufacturers, unions representing employees of such manufacturers, and consumer and environmental groups.

(c) ELIGIBLE DOMESTIC AUTOMOBILE MANUFACTURER.—To be eligible to receive financial assistance under the program established under subsection (a), a domestic automobile manufacturer shall—

(1) submit an application to the task force at such time, in such manner, and containing such information as the task force shall require;

(2) certify that such manufacturer is providing full health care coverage to all of its domestic employees;

(3) provide an assurance that the manufacturer will invest an amount equal to not less than 50 percent of the amount of health savings derived by the manufacturer as a result of its retiree health care costs being covered under the program under this section, in—

(A) the domestic manufacture and commercialization of petroleum fuel reduction technologies, including alternative or flexible fuel vehicles, hybrids, and other state-of-the-art fuel saving technologies;

(B) the retraining of workers and retooling of assembly lines for such domestic manufacture and commercialization;

(C) research and development, design, commercialization, and other costs related to the diversifying of domestic production of automobiles through the offering of high performance fuel efficient vehicles; and

(D) assisting domestic automobile component suppliers to retool their domestic manufacturing plants to produce components for petroleum fuel reduction technologies, including alternative or flexible fuel vehicles, hybrid, advanced diesel, or other state-of-the-art fuel saving technologies; and

(4) provide additional assurances and information as the task force may require, including information needed by the task force to audit the manufacturer's compliance with the requirements of the program.

(d) LIMITATION.—The total amount of financial assistance that may be provided each year under the program under this section with respect to any single domestic automobile manufacturer shall not exceed an amount equal to 10 percent of the retiree health care costs of that manufacturer for that year.

SEC. 103. REPORTING.

Not later than 6 months after the date of enactment of this Act, and every 6 months thereafter, the task force shall submit to Congress a report on any financial assistance provided under this program under this Act and the resulting changes in the manufacture and commercialization of fuel saving technologies implemented by auto manufacturers as a result of such financial assistance. Not later than 1 year after the date of enactment of this Act, the task force shall submit a report to Congress on the effectiveness of current consumer incentives available for the purchase of hybrid vehicles in encouraging the purchase of such vehicles and whether these incentives should be expanded.

SEC. 104. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated, such sums as may be necessary in each fiscal year to carry out this Act.

SEC. 105. LIMITATION ON BACKSLIDING.

To be eligible to receive financial assistance under this title, a manufacturer shall provide assurances to the task force that fuel savings achieved with respect its average adjusted fuel economy will not result in decreases with respect to fuel economy elsewhere in the domestic fleet. The task force shall determine compliance with such assurances using accepted measurements of fuel savings.

SEC. 106. TERMINATION OF PROGRAM.

The program established under this title shall terminate on December 31, 2015.

TITLE II—OFFSETS

SEC. 201. CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.

(a) IN GENERAL.—Section 7701 of the Internal Revenue Code of 1986 is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE; ETC.—

''(1) GENERAL RULES.—

''(A) IN GENERAL.—In any case in which a court determines that the economic substance doctrine is relevant for purposes of this title to a transaction (or series of transactions), such transaction (or series of transactions) shall have economic substance only if the requirements of this paragraph are met.

''(B) DEFINITION OF ECONOMIC SUBSTANCE.—For purposes of subparagraph (A)—

''(i) IN GENERAL.—A transaction has economic substance only if—

''(I) the transaction changes in a meaningful way (apart from Federal tax effects) the taxpayer's economic position, and

''(II) the taxpayer has a substantial nontax purpose for entering into such transaction and the transaction is a reasonable means of accomplishing such purpose.

In applying subclause (II), a purpose of achieving a financial accounting benefit shall not be taken into account in determining whether a transaction has a substantial nontax purpose if the origin of such financial accounting benefit is a reduction of income tax

''(ii) SPECIAL RULE WHERE TAXPAYER RELIES ON PROFIT POTENTIAL.—A transaction shall not be treated as having economic substance by reason of having a potential for profit unless—

''(I) the present value of the reasonably expected pre-tax profit from the transaction is substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected, and

''(II) the reasonably expected pre-tax profit from the transaction exceeds a risk-free rate of return.

''(C) TREATMENT OF FEES AND FOREIGN TAXES.—Fees and other transaction expenses and foreign taxes shall be taken into account as expenses in determining pre-tax profit under subparagraph (B)(ii).

''(2) SPECIAL RULES FOR TRANSACTION WITH TAX-INDIFFERENT PARTIES.—

''(A) SPECIAL RULES FOR FINANCING TRANSACTIONS.—The form of a transaction which is in substance the borrowing of money or the acquisition of financial capital directly or indirectly from a tax-indifferent party shall not be respected if the present value of the deductions to be claimed with respect to the transaction is substantially in excess of the present value of the anticipated economic returns of the person lending the money or providing the financial capital. A public offering shall be treated as a borrowing, or an acquisition of financial capital, from a tax-indifferent party if it is reasonably expected that at least 50 percent of the offering will be placed with tax-indifferent parties.

''(B) ARTIFICIAL INCOME SHIFTING AND BASIS ADJUSTMENTS.—The form of a transaction with a tax-indifferent party shall not be respected if—

''(i) it results in an allocation of income or gain to the tax-indifferent party in excess of such party's economic income or gain, or

''(ii) it results in a basis adjustment or shifting of basis on account of overstating the income or gain of the tax-indifferent party.

''(3) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

''(A) ECONOMIC SUBSTANCE DOCTRINE.—The term 'economic substance doctrine' means the common law doctrine under which tax benefits under title I with respect to a transaction are not allowable if the transaction does not have economic substance or lacks a business purpose.

''(B) TAX-INDIFFERENT PARTY.—The term 'tax-indifferent party' means any person or entity not subject to tax imposed by title I. A person shall be treated as a tax-indifferent party with respect to a transaction if the items taken into account with respect to the transaction have no substantial impact on such person's liability under title I.

''(C) EXCEPTION FOR PERSONAL TRANSACTIONS OF INDIVIDUALS.—In the case of an individual, this subsection shall apply only to transactions entered into in connection with a trade or business or an activity engaged in for the production of income.

''(D) TREATMENT OF LESSORS.—In applying paragraph (1)(B)(ii) to the lessor of tangible property subject to a lease—

''(i) the expected net tax benefits with respect to the leased property shall not include the benefits of—

''(I) depreciation,

''(II) any tax credit, or

''(III) any other deduction as provided in guidance by the Secretary, and

''(ii) subclause (II) of paragraph (1)(B)(ii) shall be disregarded in determining whether any of such benefits are allowable.

''(4) OTHER COMMON LAW DOCTRINES NOT AFFECTED.—Except as specifically provided in this subsection, the provisions of this subsection shall not be construed as altering or supplanting any other rule of law, and the requirements of this subsection shall be construed as being in addition to any such other rule of law.

''(5) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this subsection. Such regulations may include exemptions from the application of this subsection.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions entered into after the date of the enactment of this Act.

SEC. 202. PENALTY FOR UNDERSTATEMENTS ATTRIBUTABLE TO TRANSACTIONS LACKING ECONOMIC SUBSTANCE, ETC.

(a) IN GENERAL.—Subchapter A of chapter 68 of the Internal Revenue Code of 1986 is amended by inserting after section 6662A the following new section:

''SEC. 6662A. PENALTY FOR UNDERSTATEMENTS ATTRIBUTABLE TO TRANSACTIONS LACKING ECONOMIC SUBSTANCE, ETC.

''(a) IMPOSITION OF PENALTY.—If a taxpayer has an noneconomic substance transaction understatement for any taxable year, there shall be added to the tax an amount equal to 40 percent of the amount of such understatement.

''(b) REDUCTION OF PENALTY FOR DISCLOSED TRANSACTIONS.—Subsection (a) shall be applied by substituting '20 percent' for '40 percent' with respect to the portion of any noneconomic substance transaction understatement with respect to which the relevant facts affecting the tax treatment of the item are adequately disclosed in the return or a statement attached to the return.

''(c) NONECONOMIC SUBSTANCE TRANSACTION UNDERSTATEMENT.—For purposes of this section—

''(1) IN GENERAL.—The term 'noneconomic substance transaction understatement' means any amount which would be an understatement under section 6662A(b)(1) if section 6662A were applied by taking into account items attributable to noneconomic substance transactions rather than items to which section 6662A would apply without regard to this paragraph.

''(2) NONECONOMIC SUBSTANCE TRANSACTION.—The term 'noneconomic substance transaction' means any transaction if—

''(A) there is a lack of economic substance (within the meaning of section 7701(o)(1)) for the transaction giving rise to the claimed benefit or the transaction was not respected under section 7701(o)(2), or

''(B) the transaction fails to meet the requirements of any similar rule of law.

''(d) RULES APPLICABLE TO COMPROMISE OF PENALTY.—

''(1) IN GENERAL.—If the 1st letter of proposed deficiency which allows the taxpayer an opportunity for administrative review in the Internal Revenue Service Office of Appeals has been sent with respect to a penalty to which this section applies, only the Commissioner of Internal Revenue may compromise all or any portion of such penalty.

''(2) APPLICABLE RULES.—The rules of paragraphs (2) and (3) of section 6707A(d) shall apply for purposes of paragraph (1).

''(e) COORDINATION WITH OTHER PENALTIES.—Except as otherwise provided in this part, the penalty imposed by this section shall be in addition to any other penalty imposed by this title.

''(f) CROSS REFERENCES.—

''(1) For coordination of penalty with understatements under section 6662 and other special rules, see section 6662A(e).

''(2) For reporting of penalty imposed under this section to the Securities and Exchange Commission, see section 6707A(e).''.

(b) COORDINATION WITH OTHER UNDERSTATEMENTS AND PENALTIES.—

(1) The second sentence of section 6662(d)(2)(A) of the Internal Revenue Code of 1986 is amended by inserting ''and without regard to items with respect to which a penalty is imposed by section 6662B'' before the period at the end.

(2) Subsection (e) of section 6662A of the Internal Revenue Code of 1986 is amended—

(A) in paragraph (1), by inserting ''and noneconomic substance transaction understatements'' after ''reportable transaction understatements'' both places it appears,

(B) in paragraph (2)(A), by inserting ''and a noneconomic substance transaction understatement'' after ''reportable transaction understatement'',

(C) in paragraph (2)(B), by inserting ''6662B or'' before ''6663'',

(D) in paragraph (2)(C)(i), by inserting ''or section 6662B'' before the period at the end,

(E) in paragraph (2)(C)(ii), by inserting ''and section 6662B'' after ''This section'',

(F) in paragraph (3), by inserting ''or noneconomic substance transaction understatement'' after ''reportable transaction understatement'', and

(G) by adding at the end the following new paragraph:

''(3) NONECONOMIC SUBSTANCE TRANSACTION UNDERSTATEMENT.—For purposes of this subsection, the term 'noneconomic substance transaction understatement' has the meaning given such term by section 6662B(c).''.

(3) Subsection (e) of section 6707A of the Internal Revenue Code of 1986 is amended—

(A) by striking ''or'' at the end of subparagraph (B), and

(B) by striking subparagraph (C) and inserting the following new subparagraphs:

''(C) is required to pay a penalty under section 6662B with respect to any noneconomic substance transaction, or

''(D) is required to pay a penalty under section 6662(h) with respect to any transaction and would (but for section 6662A(e)(2)(C)) have been subject to penalty under section 6662A at a rate prescribed under section 6662A(c) or under section 6662B,''.

(c) CLERICAL AMENDMENT.—The table of sections for part II of subchapter A of chapter 68 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 6662A the following new item:

''Sec. 6662B. Penalty for understatements attributable to transactions lacking economic substance, etc.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions entered into after the date of the enactment of this Act.

SEC. 203. DENIAL OF DEDUCTION FOR INTEREST ON UNDERPAYMENTS ATTRIBUTABLE TO NONECONOMIC SUBSTANCE TRANSACTIONS.

(a) IN GENERAL.—Section 163(m) of the Internal Revenue Code of 1986 (relating to interest on unpaid taxes attributable to nondisclosed reportable transactions) is amended—

(1) by striking ''attributable'' and all that follows and inserting the following: ''attributable to—

''(1) the portion of any reportable transaction understatement (as defined in section 6662A(b)) with respect to which the requirement of section 6664(d)(2)(A) is not met, or

''(2) any noneconomic substance transaction understatement (as defined in section 6662B(c)).''; and

(2) by inserting ''and noneconomic substance transactions'' after ''transactions''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions after the date of the enactment of this Act in taxable years ending after such date.

SA 3870. Mr. OBAMA submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

Strike out all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Healthy Places Act of 2006''.

SEC. 2. DEFINITIONS.

In this Act:

(1) ADMINISTRATOR.—The term ''Administrator'' means the Administrator of the Environmental Protection Agency.

(2) BUILT ENVIRONMENT.—The term ''built environment'' means an environment consisting of all buildings, spaces, and products that are created or modified by people, including—

(A) homes, schools, workplaces, parks and recreation areas, greenways, business areas, and transportation systems;

(B) electric transmission lines;

(C) waste disposal sites; and

(D) land-use planning and policies that impact urban, rural, and suburban communities.

(3) DIRECTOR.—The term ''Director'' means the Director of the Centers for Disease Control and Prevention.

(4) ENVIRONMENTAL HEALTH.—The term ''environmental health'' means the health and well-being of a population as affected by—

(A) the direct pathological effects of chemicals, radiation, and some biological agents; and

(B) the effects (often indirect) of the broad physical, psychological, social, and aesthetic environment.

(5) HEALTH IMPACT ASSESSMENT.—The term ''health impact assessment'' means any combination of procedures, methods, tools, and means used under section 4 to analyze the actual or potential effects of a policy, program, or project on the health of a population (including the distribution of those effects within the population).

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 3. INTERAGENCY WORKING GROUP ON ENVIRONMENTAL HEALTH.

(a) DEFINITIONS.—In this section:

(1) INSTITUTE.—The term ''Institute'' means the Institute of Medicine of the National Academies of Science.

(2) IWG.—The term ''IWG'' means the interagency working group established under subsection (b).

(b) ESTABLISHMENT.—The Secretary, in coordination with the Administrator, shall establish an interagency working group to discuss environmental health concerns, particularly concerns disproportionately affecting disadvantaged populations.

(c) MEMBERSHIP.—The IWG shall be composed of a representative from each Federal agency (as appointed by the head of the agency) that has jurisdiction over, or is affected by, environmental policies and projects, including—

(1) the Council on Environmental Quality;

(2) the Department of Agriculture;

(3) the Department of Commerce;

(4) the Department of Defense;

(5) the Department of Education;

(6) the Department of Energy;

(7) the Department of Health and Human Services;

(8) the Department of Housing and Urban Development;

(9) the Department of the Interior;

(10) the Department of Justice;

(11) the Department of Labor;

(12) the Department of State;

(13) the Department of Transportation;

(14) the Environmental Protection Agency; and

(15) such other Federal agencies as the Administrator and the Secretary jointly determine to be appropriate.

(d) DUTIES.—The IWG shall—

(1) facilitate communication and partnership on environmental health-related projects and policies—

(A) to generate a better understanding of the interactions between policy areas; and

(B) to raise awareness of the relevance of health across policy areas to ensure that the potential positive and negative health consequences of decisions are not overlooked;

(2) serve as a centralized mechanism to coordinate a national effort—

(A) to discuss and evaluate evidence and knowledge on the relationship between the general environment and the health of the population of the United States;

(B) to determine the range of effective, feasible, and comprehensive actions to improve environmental health; and

(C) to examine and better address the influence of social and environmental determinants of health;

(3) survey Federal agencies to determine which policies are effective in encouraging, and how best to facilitate outreach without duplicating, efforts relating to environmental health promotion;

(4) establish specific goals within and across Federal agencies for environmental health promotion, including determinations of accountability for reaching those goals;

(5) develop a strategy for allocating responsibilities and ensuring participation in environmental health promotions, particularly in the case of competing agency priorities;

(6) coordinate plans to communicate research results relating to environmental health to enable reporting and outreach activities to produce more useful and timely information;

(7) establish an interdisciplinary committee to continue research efforts to further understand the relationship between the built environment and health factors (including air quality, physical activity levels, housing quality, access to primary health care practitioners and health care facilities, injury risk, and availability of nutritional, fresh food) that coordinates the expertise of the public health, urban planning, and transportation communities;

(8) develop an appropriate research agenda for Federal agencies—

(A) to support—

(i) longitudinal studies;

(ii) rapid-response capability to evaluate natural conditions and occurrences; and

(iii) extensions of national databases; and

(B) to review evaluation and economic data relating to the impact of Federal interventions on the prevention of environmental health concerns;

(9) initiate environmental health impact demonstration projects to develop integrated place-based models for addressing community quality-of-life issues;

(10) provide a description of evidence-based best practices, model programs, effective guidelines, and other strategies for promoting environmental health;

(11) make recommendations to improve Federal efforts relating to environmental health promotion and to ensure Federal efforts are consistent with available standards and evidence and other programs in existence as of the date of enactment of this Act;

(12) monitor Federal progress in meeting specific environmental health promotion goals;

(13) assist in ensuring, to the maximum extent practicable, integration of the impact of environmental policies, programs, and activities on the areas under Federal jurisdiction;

(14) assist in the implementation of the recommendations from the reports of the Institute of Medicine entitled ''Does the Built Environment Influence Physical Activity? Examining the Evidence'' and dated January 11, 2005, and ''Rebuilding the Unity of Health and the Environment: A New Vision of Environmental Health for the 21st Century'' and dated January 22, 2001, including recommendations for—

(A) the expansion of national public health and travel surveys to provide more detailed information about the connection between the built environment and health, including expansion of such surveys as—

(i) the Behavioral Risk Factor Surveillance System, the National Health and Nutrition Examination Survey, and the National Health Interview Survey conducted by the Centers for Disease Control and Prevention;

(ii) the American Community survey conducted by the Census Bureau;

(iii) the American Time Use Survey conducted by the Bureau of Labor Statistics;

(iv) the Youth Risk Behavior Survey conducted by the Centers for Disease Control and Prevention; and

(v) the National Longitudinal Cohort Survey of American Children (the National Children's Study) conducted by the National Institute of Child Health and Human Development;

(B) collaboration with national initiatives to learn from natural experiments such as observations from changes in the built environment and the consequent effects on health;

(C) development of a program of research with a defined mission and recommended budget, concentrating on multiyear projects and enhanced data collection;

(D) development of interdisciplinary education programs—

(i) to train professionals in conducting recommended research; and

(ii) to prepare practitioners with appropriate skills at the intersection of physical activity, public health, transportation, and urban planning;

(15) not later than 2 years after the date of enactment of this Act, submit to Congress a report that describes the extent to which recommendations from the Institute of Medicine reports described in paragraph (14) were executed; and

(16) assist the Director with the development of guidance for the assessment of the potential health effects of land use, housing, and transportation policy and plans.

(e) MEETINGS.—

(1) IN GENERAL.—The IWG shall meet at least 3 times each year.

(2) ANNUAL CONFERENCE.—The Secretary, acting through the Director and in collaboration with the Administrator, shall sponsor an annual conference on environmental health and health disparities to enhance coordination, build partnerships, and share best practices in environmental health data collection, analysis, and reporting.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 4. HEALTH IMPACT ASSESSMENTS.

(a) DEFINITION OF ELIGIBLE ENTITY.—In this section, the term ''eligible entity'' means any unit of State or local government the jurisdiction of which includes individuals or populations the health of which are or will be affected by an activity or a proposed activity.

(b) ESTABLISHMENT.—The Secretary, acting through the Director and in collaboration with the Administrator, shall—

(1) establish a program at the National Center of Environmental Health at the Centers for Disease Control and Prevention focused on advancing the field of health impact assessment, including—

(A) collecting and disseminating best practices;

(B) administering capacity building grants, in accordance with subsection (d);

(C) providing technical assistance;

(D) providing training;

(E) conducting evaluations; and

(F) awarding competitive extramural research grants;

(2) in accordance with subsection (f), develop guidance to conduct health impact assessments; and

(3) establish a grant program to allow eligible entities to conduct health impact assessments.

(c) GUIDANCE.—The Director, in collaboration with the IWG, shall—

(1) develop guidance for the assessment of the potential health effects of land use, housing, and transportation policy and plans, including—

(A) background on international efforts to bridge urban planning and public health institutions and disciplines, including a review of health impact assessment best practices internationally;

(B) evidence-based causal pathways that link urban planning, transportation, and housing policy and objectives to human health objectives;

(C) data resources and quantitative and qualitative forecasting methods to evaluate both the status of health determinants and health effects; and

(D) best practices for inclusive public involvement in planning decision-making;

(2) not later than 1 year after the date of enactment of this Act, promulgate the guidance; and

(3) present the guidance to the public at the annual conference described in section 3(e)(2).

(d) GRANT PROGRAM.—The Secretary, acting through the Director and in collaboration with the Administrator, shall establish a program under which the Secretary shall provide funding and technical assistance to eligible entities to prepare health impact assessments—

(1) to ensure that appropriate health factors are taken into consideration as early as practicable during any planning, review, or decision-making process; and

(2) to evaluate the effect on the health of individuals and populations, and on social and economic development, of decisions made outside of the health sector that result in modifications of a physical or social environment.

(e) APPLICATIONS.—

(1) IN GENERAL.—To receive a grant under this section, an eligible entity shall submit to the Secretary an application in accordance with this subsection, in such time, in such manner, and containing such additional information as the Secretary may require.

(2) INCLUSION.—

(A) IN GENERAL.—An application under this subsection shall include an assessment by the eligible entity of the probability that an applicable activity or proposed activity will have at least 1 significant, adverse health effect on an individual or population in the jurisdiction of the eligible entity, based on the criteria described in subparagraph (B).

(B) CRITERIA.—The criteria referred to in subparagraph (A) include, with respect to the applicable activity or proposed activity—

(i) any substantial adverse effect on—

(I) existing air quality, ground or surface water quality or quantity, or traffic or noise levels;

(II) a significant habitat area;

(III) physical activity;

(IV) injury;

(V) mental health;

(VI) social capital;

(VII) accessibility;

(VIII) the character or quality of an important historical, archeological, architectural, or aesthetic resource (including neighborhood character) of the community of the eligible entity; or

(IX) any other natural resource;

(ii) any increase in—

(I) solid waste production; or

(II) problems relating to erosion, flooding, leaching, or drainage;

(iii) any requirement that a large quantity of vegetation or fauna be removed or destroyed;

(iv) any conflict with the plans or goals of the community of the eligible entity;

(v) any major change in the quantity or type of energy used by the community of the eligible entity;

(vi) any hazard presented to human health;

(vii) any substantial change in the use, or intensity of use, of land in the jurisdiction of the eligible entity, including agricultural, open space, and recreational uses;

(viii) the probability that the activity or proposed activity will result in an increase in tourism in the jurisdiction of the eligible entity;

(ix) any substantial, adverse aggregate impact on environmental health resulting from—

(I) changes caused by the activity or proposed activity to 2 or more elements of the environment; or

(II) 2 or more related actions carried out under the activity or proposed activity; and

(x) any other significant change of concern, as determined by the eligible entity.

(C) FACTORS FOR CONSIDERATION.—In making an assessment under subparagraph (A), an eligible entity may take into consideration any reasonable, direct, indirect, or cumulative effect relating to the applicable activity or proposed activity, including the effect of any action that is—

(i) included in the long-range plan relating to the activity or proposed activity;

(ii) likely to be carried out in coordination with the activity or proposed activity;

(iii) dependent on the occurrence of the activity or proposed activity; or

(iv) likely to have a disproportionate impact on disadvantaged populations.

(f) USE OF FUNDS.—

(1) IN GENERAL.—An eligible entity shall use assistance received under this section to prepare and submit to the Secretary a health impact assessment in accordance with this subsection.

(2) PURPOSES.—The purposes of a health impact assessment are—

(A) to facilitate the involvement of State and local health officials in community planning and land use decisions to identify any potential health concern relating to an activity or proposed activity;

(B) to provide for an investigation of any health-related issue addressed in an environmental impact statement or policy appraisal relating to an activity or a proposed activity;

(C) to describe and compare alternatives (including no-action alternatives) to an activity or a proposed activity to provide clarification with respect to the costs and benefits of the activity or proposed activity; and

(D) to contribute to the findings of an environmental impact statement with respect to the terms and conditions of implementing an activity or a proposed activity, as necessary.

(3) REQUIREMENTS.—A health impact assessment prepared under this subsection shall—

(A) describe the relevance of the applicable activity or proposed activity (including the policy of the activity) with respect to health issues;

(B) assess each health impact of the applicable activity or proposed activity;

(C) provide recommendations of the eligible entity with respect to—

(i) the mitigation of any adverse impact on health of the applicable activity or proposed activity; or

(ii) the encouragement of any positive impact of the applicable activity or proposed activity;

(D) provide for monitoring of the impacts on health of the applicable activity or proposed activity, as the eligible entity determines to be appropriate; and

(E) include a list of each comment received with respect to the health impact assessment under subsection (e).

(4) METHODOLOGY.—In preparing a health impact assessment under this subsection, an eligible entity—

(A) shall follow guidelines developed by the Director, in collaboration with the IWG, that—

(i) are consistent with subsection (c);

(ii) will be established not later than 1 year after the date of enactment of this Act; and

(iii) will be made publicly available at the annual conference described in section 3(e)(2); and

(B) may establish a balance, as the eligible entity determines to be appropriate, between the use of—

(i) rigorous methods requiring special skills or increased use of resources; and

(ii) expedient, cost-effective measures.

(g) PUBLIC PARTICIPATION.—

(1) IN GENERAL.—Before preparing and submitting to the Secretary a final health impact assessment, an eligible entity shall request and take into consideration public and agency comments, in accordance with this subsection.

(2) REQUIREMENT.—Not later than 30 days after the date on which a draft health impact assessment is completed, an eligible entity shall submit the draft health impact assessment to each Federal agency, and each State and local organization, that—

(A) has jurisdiction with respect to the activity or proposed activity to which the health impact assessment applies;

(B) has special knowledge with respect to an environmental or health impact of the activity or proposed activity; or

(C) is authorized to develop or enforce any environmental standard relating to the activity or proposed activity.

(3) COMMENTS REQUESTED.—

(A) REQUEST BY ELIGIBLE ENTITY.—An eligible entity may request comments with respect to a health impact assessment from—

(i) affected Indian tribes;

(ii) interested or affected individuals or organizations; and

(iii) any other State or local agency, as the eligible entity determines to be appropriate.

(B) REQUEST BY OTHERS.—Any interested or affected agency, organization, or individual may—

(i) request an opportunity to comment on a health impact assessment; and

(ii) submit to the appropriate eligible entity comments with respect to the health impact assessment by not later than—

(I) for a Federal, State, or local government agency or organization, the date on which a final health impact assessment is prepared; and

(II) for any other individual or organization, the date described in subclause (I) or another date, as the eligible entity may determine.

(4) RESPONSE TO COMMENTS.—A final health impact assessment shall describe the response of the eligible entity to comments received within a 90-day period under this subsection, including—

(A) a description of any means by which the eligible entity, as a result of such a comment—

(i) modified an alternative recommended with respect to the applicable activity or proposed activity;

(ii) developed and evaluated any alternative not previously considered by the eligible entity;

(iii) supplemented, improved, or modified an analysis of the eligible entity; or

(iv) made any factual correction to the health impact assessment; and

(B) for any comment with respect to which the eligible entity took no action, an explanation of the reasons why no action was taken and, if appropriate, a description of the circumstances under which the eligible entity would take such an action.

(h) HEALTH IMPACT ASSESSMENT DATABASE.—The Secretary, acting through the Director and in collaboration with the Administrator, shall establish and maintain a health impact assessment database, including—

(1) a catalog of health impact assessments received under this section;

(2) an inventory of tools used by eligible entities to prepare draft and final health impact assessments; and

(3) guidance for eligible entities with respect to the selection of appropriate tools described in paragraph (2).

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as are necessary.

SEC. 5. GRANT PROGRAM.

(a) DEFINITIONS.—In this section:

(1) DIRECTOR.—The term ''Director'' means the Director of the Centers for Disease Control and Prevention, acting in collaboration with the Administrator and the Director of the National Institute of Environmental Health Sciences.

(2) ELIGIBLE ENTITY.—The term ''eligible entity'' means a State or local community that—

(A) bears a disproportionate burden of exposure to environmental health hazards;

(B) has established a coalition—

(i) with not less than 1 community-based organization; and

(ii) with not less than 1—

(I) public health entity;

(II) health care provider organization; or

(III) academic institution;

(C) ensures planned activities and funding streams are coordinated to improve community health; and

(D) submits an application in accordance with subsection (c).

(b) ESTABLISHMENT.—The Director shall establish a grant program under which eligible entities shall receive grants to conduct environmental health improvement activities.

(c) APPLICATION.—To receive a grant under this section, an eligible entity shall submit an application to the Director at such time, in such manner, and accompanied by such information as the Director may require.

(d) COOPERATIVE AGREEMENTS.—An eligible entity may use a grant under this section—

(1) to promote environmental health; and

(2) to address environmental health disparities.

(e) AMOUNT OF COOPERATIVE AGREEMENT.—

(1) IN GENERAL.—The Director shall award grants to eligible entities at the 2 different funding levels described in this subsection.

(2) LEVEL 1 COOPERATIVE AGREEMENTS.—

(A) IN GENERAL.—An eligible entity awarded a grant under this paragraph shall use the funds to identify environmental health problems and solutions by—

(i) establishing a planning and prioritizing council in accordance with subparagraph (B); and

(ii) conducting an environmental health assessment in accordance with subparagraph (C).

(B) PLANNING AND PRIORITIZING COUNCIL.—

(i) IN GENERAL.—A prioritizing and planning council established under subparagraph (A)(i) (referred to in this paragraph as a ''PPC'') shall assist the environmental health assessment process and environmental health promotion activities of the eligible entity.

(ii) MEMBERSHIP.—Membership of a PPC shall consist of representatives from various organizations within public health, planning, development, and environmental services and shall include stakeholders from vulnerable groups such as children, the elderly, disabled, and minority ethnic groups that are often not actively involved in democratic or decision-making processes.

(iii) DUTIES.—A PPC shall—

(I) identify key stakeholders and engage and coordinate potential partners in the planning process;

(II) establish a formal advisory group to plan for the establishment of services;

(III) conduct an in-depth review of the nature and extent of the need for an environmental health assessment, including a local epidemiological profile, an evaluation of the service provider capacity of the community, and a profile of any target populations; and

(IV) define the components of care and form essential programmatic linkages with related providers in the community.

(C) ENVIRONMENTAL HEALTH ASSESSMENT.—

(i) IN GENERAL.—A PPC shall carry out an environmental health assessment to identify environmental health concerns.

(ii) ASSESSMENT PROCESS.—The PPC shall—

(I) define the goals of the assessment;

(II) generate the environmental health issue list;

(III) analyze issues with a systems framework;

(IV) develop appropriate community environmental health indicators;

(V) rank the environmental health issues;

(VI) set priorities for action;

(VII) develop an action plan;

(VIII) implement the plan; and

(IX) evaluate progress and planning for the future.

(D) EVALUATION.—Each eligible entity that receives a grant under this paragraph shall evaluate, report, and disseminate program findings and outcomes.

(E) TECHNICAL ASSISTANCE.—The Director may provide such technical and other non-financial assistance to eligible entities as the Director determines to be necessary.

(3) LEVEL 2 COOPERATIVE AGREEMENTS.—

(A) ELIGIBILITY.—

(i) IN GENERAL.—The Director shall award grants under this paragraph to eligible entities that have already—

(I) established broad-based collaborative partnerships; and

(II) completed environmental assessments.

(ii) NO LEVEL 1 REQUIREMENT.—To be eligible to receive a grant under this paragraph, an eligible entity is not required to have successfully completed a Level 1 Cooperative Agreement (as described in paragraph (2).

(B) USE OF GRANT FUNDS.—An eligible entity awarded a grant under this paragraph shall use the funds to further activities to carry out environmental health improvement activities, including—

(i) addressing community environmental health priorities in accordance with paragraph (2)(C)(ii), including—

(I) air quality;

(II) water quality;

(III) solid waste;

(IV) land use;

(V) housing;

(VI) food safety;

(VII) crime;

(VIII) injuries; and

(IX) healthcare services;

(ii) building partnerships between planning, public health, and other sectors, to address how the built environment impacts food availability and access and physical activity to promote healthy behaviors and lifestyles and reduce obesity and related comorbidities;

(iii) establishing programs to address—

(I) how environmental and social conditions of work and living choices influence physical activity and dietary intake; or

(II) how those conditions influence the concerns and needs of people who have impaired mobility and use assistance devices, including wheelchairs and lower limb prostheses; and

(iv) convening intervention programs that examine the role of the social environment in connection with the physical and chemical environment in—

(I) determining access to nutritional food; and

(II) improving physical activity to reduce morbidity and increase quality of life.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $25,000,000 for fiscal year 2007; and

(2) such sums as are necessary for the period of fiscal years 2008 through 2011.

SEC. 6. ADDITIONAL RESEARCH ON THE RELATIONSHIP BETWEEN THE BUILT ENVIRONMENT AND THE HEALTH OF COMMUNITY RESIDENTS.

(a) DEFINITION OF ELIGIBLE INSTITUTION.—In this section, the term ''eligible institution'' means a public or private nonprofit institution that submits to the Secretary and the Administrator an application for a grant under the grant program authorized under subsection (b)(2) at such time, in such manner, and containing such agreements, assurances, and information as the Secretary and Administrator may require.

(b) RESEARCH GRANT PROGRAM.—

(1) DEFINITION OF HEALTH.—In this section, the term ''health'' includes—

(A) levels of physical activity;

(B) consumption of nutritional foods;

(C) rates of crime;

(D) air, water, and soil quality;

(E) risk of injury;

(F) accessibility to healthcare services; and

(G) other indicators as determined appropriate by the Secretary.

(2) GRANTS.—The Secretary, in collaboration with the Administrator, shall provide grants to eligible institutions to conduct and coordinate research on the built environment and its influence on individual and population-based health.

(3) RESEARCH.—The Secretary shall support research that—

(A) investigates and defines the causal links between all aspects of the built environment and the health of residents;

(B) examines—

(i) the extent of the impact of the built environment (including the various characteristics of the built environment) on the health of residents;

(ii) the variance in the health of residents by—

(I) location (such as inner cities, inner suburbs, and outer suburbs); and

(II) population subgroup (such as children, the elderly, the disadvantaged); or

(iii) the importance of the built environment to the total health of residents, which is the primary variable of interest from a public health perspective;

(C) is used to develop—

(i) measures to address health and the connection of health to the built environment; and

(ii) efforts to link the measures to travel and health databases;

(D) distinguishes carefully between personal attitudes and choices and external influences on observed behavior to determine how much an observed association between the built environment and the health of residents, versus the lifestyle preferences of the people that choose to live in the neighborhood, reflects the physical characteristics of the neighborhood; and

(E)(i) identifies or develops effective intervention strategies to promote better health among residents with a focus on behavioral interventions and enhancements of the built environment that promote increased use by residents; and

(ii) in developing the intervention strategies under clause (i), ensures that the intervention strategies will reach out to high-risk populations, including low-income urban and rural communities.

(4) PRIORITY.—In providing assistance under the grant program authorized under paragraph (2), the Secretary and the Administrator shall give priority to research that incorporates—

(A) interdisciplinary approaches; or

(B) the expertise of the public health, physical activity, urban planning, and transportation research communities in the United States and abroad.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SA 3871. Mrs. FEINSTEIN (for herself, Mr. DORGAN, Mr. BINGAMAN, and Ms. STABENOW) submitted an amendment intended to be proposed by her to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Drug Formulary Protection Act''.

SEC. 2. REMOVAL OF COVERED PART D DRUGS FROM THE PRESCRIPTION DRUG PLAN FORMULARY.

(a) LIMITATION ON REMOVAL OR CHANGE OF COVERED PART D DRUGS FROM THE PRESCRIPTION DRUG PLAN FORMULARY.—Section 1860D–4(b)(3)(E) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)(E)) is amended to read as follows:

''(E) REMOVING A DRUG FROM FORMULARY OR IMPOSING A RESTRICTION OR LIMITATION ON COVERAGE.—

''(i) LIMITATION ON REMOVAL, LIMITATION, OR RESTRICTION.—

''(I) IN GENERAL.—Subject to subclause (II) and clause (ii), beginning with 2006, the PDP sponsor of a prescription drug plan may not remove a covered part D drug from the plan formulary or impose a restriction or limitation on the coverage of such a drug (such as through the application of a preferred status, usage restriction, step therapy, prior authorization, or quantity limitation) other than at the beginning of each plan year.

''(II) SPECIAL RULE FOR NEWLY ENROLLED INDIVIDUALS.—Subject to clause (ii), in the case of an individual who enrolls in a prescription drug plan on or after the date of enactment of this subparagraph, the PDP sponsor of such plan may not remove a covered part D drug from the plan formulary or impose a restriction or limitation on the coverage of such a drug (such as through the application

of a preferred status, usage restriction, step therapy, prior authorization, or quantity limitation) during the period beginning on the date of such enrollment and ending on December 31 of the immediately succeeding plan year.

''(ii) EXCEPTIONS TO LIMITATION ON REMOVAL.—Clause (i) shall not apply with respect to a covered part D drug that—

''(I) is a brand name drug for which there is a generic drug approved under section 505(j) of the Food and Drug Cosmetic Act (21 U.S.C. 355(j)) that is placed on the market during the period in which there are limitations on removal or change in the formulary under clause (i);

''(II) is a brand name drug that goes off-patent during such period;

''(III) is a drug for which the Commissioner of Food and Drugs issues a clinical warning that imposes a restriction or limitation on the drug during such period or removes the drug from the market;

''(IV) is a drug that the plan's pharmacy and therapeutic committee determines, based on scientific evidence, to be unsafe or ineffective during such period; or

''(V) is a drug for which the Secretary has determined an exception to such application is appropriate (such as to take into account new therapeutic uses and newly covered part D drugs).

''(iii) NOTICE OF REMOVAL UNDER APPLICATION OF EXCEPTION TO LIMITATION.—The PDP sponsor of a prescription drug plan shall provide appropriate notice (such as under subsection (a)(3)) of any removal or change under clause (ii) to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists.''.

(b) NOTICE FOR CHANGE IN FORMULARY AND OTHER RESTRICTIONS OR LIMITATIONS ON COVERAGE.—

(1) IN GENERAL.—Section 1860D–4(a) of such Act (42 U.S.C. 1395w–104(a)) is amended by adding at the end the following new paragraph:

''(5) ANNUAL NOTICE OF CHANGES IN FORMULARY AND OTHER RESTRICTIONS OR LIMITATIONS ON COVERAGE.—Each PDP sponsor offering a prescription drug plan shall furnish to each enrollee at the time of each annual coordinated election period (referred to in section 1860D–1(b)(1)(B)(iii)) for a plan year a notice of any changes in the formulary or other restrictions or limitations on coverage of a covered part D drug under the plan that will take effect for the plan year.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to annual, coordinated election periods beginning after the date of the enactment of this Act.

SA 3872. Mr. KERRY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place insert the following:

SEC. ___. CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following:

''SEC. 45N. EMPLOYEE HEALTH INSURANCE EXPENSES.

''(a) GENERAL RULE.—For purposes of section 38, in the case of a qualified small employer, the employee health insurance expenses credit determined under this section is an amount equal to the applicable percentage of the amount paid by the taxpayer during the taxable year for qualified employee health insurance expenses.

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage is—

''(1) 50 percent in the case of an employer with less than 10 qualified employees,

''(2) 25 percent in the case of an employer with more than 9 but less than 25 qualified employees, and

''(3) 20 percent in the case of an employer with more than 24 but less than 50 qualified employees.

''(c) PER EMPLOYEE DOLLAR LIMITATION.—

''(1) IN GENERAL.—The amount of qualified employee health insurance expenses taken into account under subsection (a) with respect to any qualified employee for any taxable year shall not exceed—

''(A) $4,000 for self-only coverage, and

''(B) $10,000 for family coverage.

''(2) PHASEOUT OF PER EMPLOYEE DOLLAR LIMITATION.—

''(A) IN GENERAL.—The amount determined under paragraph (1) with respect to any qualified employee for any taxable year shall be reduced by the amount determined under subparagraph (B).

''(B) AMOUNT OF REDUCTION.—The amount determined under this subparagraph shall be the amount which bears the same ratio to such amount determined under paragraph (1) as—

''(i) the excess of—

''(I) the qualified employee's compensation from the qualified small employer for such taxable year, over

''(II) $30,000, bears to

''(ii) $20,000.

The rules of subparagraphs (B) and (C) of section 219(g)(2) shall apply to any reduction under this subparagraph.

''(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) QUALIFIED SMALL EMPLOYER.—

''(A) IN GENERAL.—The term 'qualified small employer' means any small employer which—

''(i) provides eligibility for health insurance coverage (after any waiting period (as defined in section 9801(b)(4))) to all qualified employees of the employer under similar terms, and

''(ii) pays at least 50 percent of the cost of such coverage for each qualified employee.

''(B) SMALL EMPLOYER.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'small employer' means, with respect to any taxable year, any employer if—

''(I) the average gross receipts of such employer for the preceding 3 taxable years does not exceed $5,000,000, and

''(II) such employer employed an average of more than 1 but less than 50 employees on business days during the preceding taxable year.

''(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—For purposes of clause (i)(II)—

''(I) a preceding taxable year may be taken into account only if the employer was in existence throughout such year, and

''(II) in the case of an employer which was not in existence throughout the preceding taxable year, the determination of whether such employer is a qualified small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current taxable year.

''(iii) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414 shall be treated as one person for purposes of this subparagraph.

''(iv) PREDECESSORS.—The Secretary may prescribe regulations which provide for references in this subparagraph to an employer to be treated as including references to predecessors of such employer.

''(2) QUALIFIED EMPLOYEE HEALTH INSURANCE EXPENSES.—

''(A) IN GENERAL.—The term 'qualified employee health insurance expenses' means any amount paid by an employer for health insurance coverage to the extent such amount is attributable to coverage provided to any employee while such employee is a qualified employee.

''(B) EXCEPTION FOR AMOUNTS PAID UNDER SALARY REDUCTION ARRANGEMENTS.—No amount paid or incurred for health insurance coverage pursuant to a salary reduction arrangement shall be taken into account under subparagraph (A).

''(C) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term by section 9832(b)(1).

''(3) QUALIFIED EMPLOYEE.—

''(A) IN GENERAL.—The term 'qualified employee' means an employee of an employer who, with respect to any period, is not provided health insurance coverage under—

''(i) a health plan of the employee's spouse,

''(ii) title XVIII, XIX, or XXI of the Social Security Act,

''(iii) chapter 17 of title 38, United States Code,

''(iv) chapter 55 of title 10, United States Code,

''(v) chapter 89 of title 5, United States Code, or

''(vi) any other provision of law.

For purposes of clause (i), the Secretary shall prescribe by regulation the manner by which an employee's health insurance coverage under a health plan of the employee's spouse is certified to the employee's employer.

''(B) EMPLOYEE.—The term 'employee'—

''(i) means any individual, with respect to any calendar year, who is reasonably expected to receive at least $5,000, but not more than $50,000, of compensation from the employer during such year, and

''(ii) includes a leased employee within the meaning of section 414(n).

''(C) COMPENSATION.—The term 'compensation' means amounts described in section 6051(a)(3).

''(D) INFLATION ADJUSTMENT.—

''(i) IN GENERAL.—In the case of a taxable year beginning after 2007, the $50,000 amount in subparagraph (B)(i) shall be increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2006' for 'calendar year 1992' in subparagraph (B) thereof.

''(ii) ROUNDING.—If any amount as adjusted under clause (i) is not a multiple of $1,000, such amount shall be rounded to the next lowest multiple of $1,000.

''(e) PORTION OF CREDIT MADE REFUNDABLE.—

''(1) IN GENERAL.—The aggregate credits allowed to a taxpayer under subpart C shall be increased by the lesser of—

''(A) the credit which would be allowed under subsection (a) without regard to this subsection and the limitation under section 38(c), or

''(B) the amount by which the aggregate amount of credits allowed by this subpart (determined without regard to this subsection) would increase if the limitation imposed by section 38(c) for any taxable year

were increased by the amount of employer payroll taxes imposed on the taxpayer during the calendar year in which the taxable year begins.

The amount of the credit allowed under this subsection shall not be treated as a credit allowed under this subpart and shall reduce the amount of the credit otherwise allowable under subsection (a) without regard to section 38(c).

''(2) EMPLOYER PAYROLL TAXES.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'employer payroll taxes' means the taxes imposed by—

''(i) subsections (a) and (b) of section 3111, and

''(ii) sections 3211(a) and 3221(a) (determined at a rate equal to the sum of the rates under subsections (a) and (b) of section 3111).

''(B) SPECIAL RULE.—A rule similar to the rule of section 24(d)(2)(C) shall apply for purposes of subparagraph (A).

''(f) DENIAL OF DOUBLE BENEFIT.—No deduction or credit under any other provision of this chapter shall be allowed with respect to qualified employee health insurance expenses taken into account under subsection (a).''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of the Internal Revenue Code of 1986 (relating to current year business credit) is amended by striking ''and'' at the end of paragraph (29), by striking the period at the end of paragraph (30) and inserting '', plus'', and by adding at the end the following:

''(31) the employee health insurance expenses credit determined under section 45N.''.

(c) CONFORMING AMENDMENT.—Section 6211(b)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''and 34'' and inserting ''34, and 45N(e)''.

(d) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''Sec. 45N. Employee health insurance expenses.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2006.

SA 3873. Mr. LEAHY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. MEDICAL MALPRACTICE INSURANCE ANTITRUST PROVISIONS.

(a) SHORT TITLE.—This section may be cited as the ''Medical Malpractice Insurance Antitrust Act of 2005''.

(b) PROHIBITION ON ANTI-COMPETITIVE ACTIVITIES.—Notwithstanding any other provision of law, nothing in the Act of March 9, 1945 (15 U.S.C. 1011 et seq., commonly known as the ''McCarran-Ferguson Act'') shall be construed to permit commercial insurers to engage in any form of price fixing, bid rigging, or market allocations in connection with the conduct of the business of providing medical malpractice insurance.

(c) APPLICATION TO ACTIVITIES OF STATE COMMISSIONS OF INSURANCE AND OTHER STATE INSURANCE REGULATORY BODIES.—This section does not apply to the information gathering and rate setting activities of any State commissions of insurance, or any other State regulatory body with authority to set insurance rates.

AUTHORITY FOR COMMITTEES TO MEET

SUBCOMMITTEE ON AVIATION

Mr. ENZI. Mr. President. I ask unanimous consent that the Senate Committee on Commerce Science and Transportation's Subcommittee on Aviation be authorized to meet on Tuesday, May 9, 2006, at 2:30 p.m. on the Department of Transportation's Notice of Proposed Rulemaking.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

Mr. ENZI. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions, Subcommittee on Employment and Workplace Safety, be authorized to hold a hearing during the session of the Senate on Tuesday, May 9, 2006 at 10 a.m. in SD–430.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. ENZI. Mr. President, I ask unanimous consent that the Senate Committee on the Judiciary be authorized to meet to conduct a hearing on ''Judicial Nominations'' on Tuesday, May 9, 2006, at 2 p.m. in Room 226 of the Dirksen Senate Office Building. The witness list will be provided when it becomes available.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. ENZI. Mr. President, I ask unanimous consent that the Senate Committee on the Judiciary be authorized to meet to conduct a hearing on ''An Introduction to the Expiring Provisions of the Voting Rights Act and Legal Issues Relating to Reauthorization'' on Tuesday, May 9, 2006, at 9:30 a.m. in Room 226 of the Dirksen Senate Office Building.

Witness List:

Panel I: Chandler Davidson, Radoslav Tsanoff Professor Emeritus and Research Professor, Rice University, Houston, TX; Ted Shaw, Director-Counsel and President, NAACP Legal Defense and Educational Fund, Inc. (LDF), New York City, NY; Richard L. Hasen, William H. Hannon Distinguished Professor of Law, Loyola Law School, Los Angeles, CA; Laughlin McDonald, Director of the ACLU Voting Rights Project, Atlanta, GA; and Samuel Issacharoff, Reiss Professor of Constitutional Law, New York University School of Law, New York, NY.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON SURFACE TRANSPORTATION AND MERCHANT MARINE

Mr. ENZI. Mr. President, I ask unanimous consent that the Senate Committee on Commerce, Science, and Transportation's Subcommittee on Surface Transportation and Merchant Marine be authorized to meet on Tuesday, May 9, 2006, at 10 a.m. on Corporate Average Fuel Economy (CAFE) Standards.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGES OF THE FLOOR

Mr. DODD. Mr. President, I ask unanimous consent that Elizabeth Hoffman, a fellow in my office, be granted the privileges of the floor for the duration of the debate on this legislation.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WYDEN. Mr. President, on behalf of Senator BAUCUS, I ask unanimous consent that the following interns and fellows be granted floor privileges during consideration of S. 1955: Leona Cutler, David Schwartz, Diedra Henry-Spires, Britt Sandler, Tiffany Smith, Tom Louthan, and Christal Edwards.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HARKIN. Mr. President, I ask unanimous consent that Courtney Wilcox of my staff be granted floor privileges for the duration of today's session.

The PRESIDING OFFICER. Without objection, it is so ordered.

APPOINTMENTS

The PRESIDING OFFICER. The Chair, on behalf of the majority leader, after consultation with the ranking member of the Senate Committee on Finance, pursuant to Public Law 106–170, announces the appointment of the following individual to serve as a member of the Ticket to Work and Work Incentives Advisory Panel: Katie Beckett of Iowa.

The Chair, on behalf of the majority leader, in consultation with the Democratic Leader, pursuant to Public Law 68–541, as amended by Public Law 102–246, appoints John Medveckis, of Pennsylvania, as a member of the Library of Congress Trust Fund Board for a term of 5 years.

NATIONAL FOSTER CARE MONTH

Mr. VOINOVICH. Mr. President, I ask unanimous consent that the Senate now proceed to the consideration of S. Res. 471 which was submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 471) recognizing that, during National Foster Care Month, the leaders of the Federal, State, and local governments should provide leadership to improve the care given to children in foster care programs.

There being no objection, the Senate proceeded to consider the resolution.

Mr. VOINOVICH. Mr. President, I ask unanimous consent that the resolution

be agreed to, the preamble be agreed to, and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 471) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. Res. 471

Whereas more than 500,000 children are in foster care programs throughout the United States;

Whereas, while approximately ¼ of all children in foster care programs are available for adoption, only about 50,000 foster children are adopted each year;

Whereas many of the children in foster care programs have endured—

(1) numerous years in the foster care system; and

(2) frequent moves to and from foster homes;

Whereas approximately 50 percent of foster care children have been placed in foster care programs for longer than 1 year;

Whereas 25 percent of foster care children have been placed in foster care programs for at least 3 years;

Whereas children who spend longer amounts of time in foster care programs often experience worse outcomes than children who are placed for shorter periods of time;

Whereas children who spend time in foster care programs are more likely to—

(1) become teen parents;

(2) rely on public assistance when they become adults; and

(3) interact with the criminal justice system;

Whereas Federal, State, and local governments—

(1) share a unique relationship with foster children; and

(2) have removed children from their homes to better provide for the safety, permanency, and well-being of the children;

Whereas unfortunately, studies indicate that Federal, State, and local governments have not been entirely successful in caring for foster children;

Whereas Congress recognizes the commitment of Federal, State, and local governments to ensure the safety and permanency of children placed in foster care programs; and

Whereas every child deserves a loving family: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes—

(A) May 2006 as ''National Foster Care Month''; and

(B) that, during National Foster Care Month, the leaders of the Federal, State, and local governments should rededicate themselves to provide better care to the foster children of the United States; and

(2) resolves to provide leadership to help identify the role that Federal, State, and local governments should play to ensure that foster children receive appropriate parenting throughout their entire childhood.

ORDERS FOR WEDNESDAY, MAY 10, 2006

Mr. VOINOVICH. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 9:30 a.m. on Wednesday, May 10. I further ask that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to dare, the time for the two leaders be reserved, and the Senate proceed to a period of morning business for up to 60 minutes, with the first 30 minutes under the control of the majority leader or his designee and the final 30 minutes under the control of the Democratic leader or his designee; further, that the Senate then begin consideration of S. 1955, the small business health plans bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. VOINOVICH. Mr. President, today cloture was invoked on the motion to proceed to the small business health plans bill by a vote of 96 to 2. Tomorrow morning, we will begin consideration of the bill. Chairman ENZI will be here and will be available to discuss relevant amendments that Senators may want to offer during tomorrow's session. Therefore, rollcall votes are possible during Wednesday's session on the small business health plans-related amendments.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. VOINOVICH. Mr. President, if there is no further business to come before the Senate, I ask that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 7:31 p.m., adjourned until Wednesday, May 10, 2006, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate May 9, 2006:

DEPARTMENT OF THE TREASURY

ERIC SOLOMON, OF NEW JERSEY, TO BE AN ASSISTANT SECRETARY OF THE TREASURY, VICE PAMELA F. OLSON, RESIGNED.

NATIONAL COUNCIL ON DISABILITY

VICTORIA RAY CARLSON, OF IOWA, TO BE A MEMBER OF THE NATIONAL COUNCIL ON DISABILITY FOR A TERM EXPIRING SEPTEMBER 17, 2007, VICE JOEL KAHN, TERM EXPIRED.

CHAD COLLEY, OF FLORIDA, TO BE A MEMBER OF THE NATIONAL COUNCIL ON DISABILITY FOR A TERM EXPIRING SEPTEMBER 17, 2007, VICE DAVID WENZEL, TERM EXPIRED.

LISA MATTHEISS, OF TENNESSEE, TO BE A MEMBER OF THE NATIONAL COUNCIL ON DISABILITY FOR A TERM EXPIRING SEPTEMBER 17, 2007, VICE CAROL HUGHES NOVAK, TERM EXPIRED.

JOHN R. VAUGHN, OF FLORIDA, TO BE A MEMBER OF THE NATIONAL COUNCIL ON DISABILITY FOR A TERM EXPIRING SEPTEMBER 17, 2007, VICE LEX FRIEDEN, TERM EXPIRED.

UNITED STATES POSTAL SERVICE

ELLEN C. WILLIAMS, OF KENTUCKY, TO BE A GOVERNOR OF THE UNITED STATES POSTAL SERVICE FOR THE REMAINDER OF THE TERM EXPIRING DECEMBER 8, 2007, VICE JOHN S. GARDNER.

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be rear admiral (lower half)

CAPT. THOMAS P. MEEK, 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be read admiral (lower half)

CAPT. JANICE M. HAMBY, 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be rear admiral (lower half)

CAPT. STEVEN R. EASTBURG, 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be read admiral (lower half)

CAPT. GREGORY J. SMITH, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be rear admiral (lower half)

CAPT. JOSEPH F. CAMPBELL, 0000
CAPT. THOMAS J. ECCLES, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be rear admiral (lower half)

CAPTAIN TOWNSEND G. ALEXANDER, 0000
CAPTAIN DAVID H. BUSS, 0000
CAPTAIN KENDALL L. CARD, 0000
CAPTAIN JOHN N. CHRISTENSON, 0000
CAPTAIN MICHAEL J. CONNOR, 0000
CAPTAIN JOHN ELNITSKY II, 0000
CAPTAIN KENNETH E. FLOYD, 0000
CAPTAIN PHILIP H. GREENE, 0000
CAPTAIN BRUCE E. GROOMS, 0000
CAPTAIN JAMES C. GRUNEWALD, 0000
CAPTAIN EDWARD S. HEBNER, 0000
CAPTAIN MICHELLE J. HOWARD, 0000
CAPTAIN ARNOLD O. LOTRING, JR, 0000
CAPTAIN JAMES P. MCMANAMON, 0000
CAPTAIN JOSEPH P. MULLOY, 0000
CAPTAIN CHARLES E. SMITH, 0000
CAPTAIN SCOTT H. SWIFT, 0000
CAPTAIN DAVID M. THOMAS, 0000
CAPTAIN KURT W. TIDD, 0000
CAPTAIN MICHAEL P. TILLOTSON, 0000
CAPTAIN MARK A. VANCE, 0000
CAPTAIN GARRY R. WHITE, 0000
CAPTAIN EDWARD G. WINTERS III, 0000